CPS INSURANCE SERVICES

QUICK QUOTE FOR DRIVING VIOLATIONS

CLIENT: NAME _____ / ☐ M ☐F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ☐UL ☐ TERM YRS. LVL _____

TOBACCO USE ☐ NO ☐YES, TYPE _____ / REPLACEMENT ☐YES ☐NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ☐ SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

FAMILY HISTORY –
AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET_____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☐ NO ☐YES, DETAILS_ _____

DATE OF LAST MEDICAL CHECKUP _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS_____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____/ ARE YOU TREATED FOR BLOOD PRESSURE? ☐ NO ☐YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____/ARE YOU TREATED FOR CHOLESTEROL? ☐ NO ☐YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

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1. PLEASE LIST DATES OF ALL MOVING VIOLATIONS OVER THE PAST FIVE YEARS:

MONTH _____ YEAR _____

MONTH _____ YEAR _____

MONTH _____ YEAR _____

MONTH _____ YEAR _____

2. DOES CLIENT CURRENTLY HOLD A VALID DRIVER'S LICENSE?

☐ NO ☐YES, STATE _____ EXPIRATION DATE _____

3. PLEASE PROVIDE DETAILS REGARDING ANY ACCIDENTS:

☐ NONE

DETAIL _____

MONTH _____ YEAR _____

DETAIL _____

MONTH _____ YEAR _____

4. WITHIN THE LAST 10 YEARS, PLEASE PROVIDE DETAILS REGARDING ANY DRIVING UNDER THE INFLUENCE (DUI) CONVICTIONS AND/ OR ARRESTS:

DETAIL _____

MONTH _____ YEAR _____

DETAIL _____

MONTH _____ YEAR _____

6. HAS CLIENT EVER BEEN TREATED FOR SUBSTANCE ABUSE?
☐ NO ☐YES, DETAIL:

MONTH(S) _____ YEAR _____

PLACE _____

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN:

_____

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