

QUICK QUOTE FOR HEPATITIS (or Elevated Liver Functions)

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 _____

1. PLEASE LIST DATE AND RESULTS OF CLIENT'S MOST RECENT LIVER FUNCTION TESTS:
RESULT DATE#1 RESULT DATE#2

AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. CHECK TYPE, AND LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

A DATE _____ NEG POS
 B DATE _____ NEG POS
 C DATE _____ NEG POS

HBV RNA
(for Hep B) DATE _____ RESULT _____

HCV RNA
(for Hep C) DATE _____ RESULT _____

3. HAS THE CLIENT HAD A LIVER BIOPSY?

NO YES, DETAIL DATE AND RESULTS _____

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH (CHECK AND DETAIL ANY/ALL THAT APPLY):

FATTY LIVER, DETAILS _____
 HEPATITIS, TYPE: ACUTE CHRONIC
 DETAILS _____
 CIRRHOSIS, DETAILS _____

5. HAS THE CLIENT EVER BEEN TREATED FOR HEPATITIS?

YES NO
 IF YES, DATE OF TREATMENT _____

TYPE OF TREATMENT (EX: INTERFERON, RIBAVARIN)

6. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

NO YES, DETAIL FREQUENCY AND AMOUNT: _____
 IF NO, DATE OF LAST DRINK: MONTH _____ YEAR _____

7. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

0 TO 6 MONTHS AGO
 6 TO 12 MONTHS AGO
 12 TO 24 MONTHS AGO
 OVER 2 YEARS AGO

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTES FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS TAKEN:

