CPS INSURANCE SERVICES

QUICK QUOTE FOR LIVER TRANSPLANT

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 NOTE DISORDER THAT MADE THE LIVER TRANSPLANT NECESSARY:

- ❑ AUTOIMMUNE CIRRHOSIS
- ❑ HEMOCHROMATOSIS
- ❑ PRIMARY BILIARY CIRRHOSIS
- ❑ HEPATITIS
- ❑ OTHER, PLEASE DETAIL _____

2. DATE OF THE TRANSPLANT _____

3. ARE THERE ANY CURRENT SYMPTOMS/COMPLICATIONS?

❑ NO ❑ YES, DETAILS _____

_____

4. GIVE RESULTS OF MOST RECENT LIVER FUNCTION TESTS:

AST(SGOT) _____ALT(SGPT) _____

GGT_____ALKALINE PHOSPHATASE _____

ALBUMIN_____BILLIRUBIN _____

5. PLEASE NOTE ANY OF THE FOLLOWING THAT HAVE OCCURRED (CHECK ALL THAT APPLY):

- ❑ FREQUENT INFECTION
- ❑ REJECTION EPISODES
- ❑ HIGH BLOOD PRESSURE
- ❑ CARDIOVASCULAR DISEASE
- ❑ TOXICITY FROM TREATMENT
- ❑ CANCER
- ❑ DISEASE RECURRENCE

6. PLEASE DETAIL ANY CURRENT TREATMENT PRESCRIBED:

_____

_____

7. DATE OF THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOW UP ON THE TRANSPLANT:

_____

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

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