CPS INSURANCE SERVICES

QUICK QUOTE FOR PARALYSIS AND SPINAL CORD INJURY

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. WHAT WAS CAUSE OF PARALYSIS?
☐TRAUMA – GIVE DETAILS AND DATE OF OCCURRENCE:
_____

☐SURGERY – GIVE DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE:
_____

☐STROKE (CVA OR CEREBROVASCULAR ACCIDENT) – GIVE DATE OF OCCURRENCE:
_____

☐OTHER – PLEASE GIVE DETAILS:
_____

2. PLEASE NOTE CURRENT LEVEL OF FUNCTION:

☐INCOMPLETE PARAPLEGIA
☐COMPLETE PARAPLEGIA
☐INCOMPLETE QUADRIPLEGIA
☐COMPLETE QUADRIPLEGIA

3. IF PARALYSIS FROM INJURY OR TRAUMA, AT WHAT SPINAL CORD LEVEL (LIST SPECIFIC LOCATION IF AVAILABLE; EX. C7-C8):

☐CERVICAL SPINE _____

☐THORACIC SPINE _____

☐LUMBROSACRAL SPINE _____

4. HAVE ANY OF THE FOLLOWING OCCURRED (CHECK ALL THAT APPLY):

☐PNEUMONIA
☐SKIN ULCERS
☐URINARY TRACT INFECTION
☐KIDNEY IMPAIRMENT
☐DEPRESSION

5. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS (CHECK ALL THAT APPLY):

☐NORMAL BLADDER FUNCTION, OR ☐NEEDS ASSISTANCE
☐NORMAL BOWEL FUNCTIONS, OR ☐NEEDS ASSISTANCE
☐USES CANE ONLY
☐WHEEL CHAIR BOUND
☐BED BOUND
☐NEEDS ASSITANCE EATING
☐NEEDS ASSISTANCE TO COMMUNICATE

6. IS TREATMENT CURRENTLY PRESCRIBED?

☐NO ☐YES, DETAILS _____

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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