CPS INSURANCE SERVICES

QUICK QUOTE FOR PARKINSON'S DISEASE

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 OF INITIAL DIAGNOSIS _______________

2. PLEASE NOTE THE CURRENT FUNCTIONAL STAGE:

☐ STAGE 1– UNILATERAL INVOLVEMENT

☐ STAGE 2– BILATERAL INVOLVEMENT, BUT NORMAL STANCE

☐ STAGE 3– BILATERAL INVOLVEMENT WITH MILD POSTURAL IMBALANCE, BUT ABLE TO LEAD AN INDEPENDENT LIFE

☐ STAGE 4– BILATERAL INVOLVEMENT WITH POSTURAL INSTABILITY, REQUIRES SUBSTANTIAL HELP

☐ STAGE 5– SEVERE DISEASE, RESTRICTED TO BED OR WHEELCHAIR

3. PLEASE LIST CURRENT MEDICATIONS:

____

____

4. HAS THERE BEEN ANY EVIDENCE OF PROGRESSION?

☐ NO ☐YES, DETAILS ________________________________

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

☐ DEMENTIA
☐ MEMORY PROBLEMS
☐ ASPIRATION
☐ RECURRENT INFECTIONS
☐ FALLS
☐ RECURRENT INJURIES

PLEASE PROVIDE DETAILS TO ANY CHECKED RESPONSES:

____

____

____

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

____

____

____