

QUICK QUOTE FOR STROKE (CVA) / MINI-STROKE (TIA)

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 _____

1. PLEASE SPECIFY IF CVA (STROKE) OR TIA (MINI-STROKE) :

2. PROVIDE DATE OF CLIENT'S FIRST STROKE OR TIA:
MONTH _____ YEAR _____

3. PROVIDE DATE OF CLIENT'S LAST STROKE OR TIA:
MONTH _____ YEAR _____

4. CAUSE OF STROKE OR TIA (IF KNOWN):

5. TYPE OF STROKE (IF KNOWN):

- ISCHEMIC
 HEMORRHAGIC
 LACUNAR INFARCT

6. PLEASE NOTE NUMBER OF STROKES OR TIA'S SUFFERED DURING THE PAST 24 MONTHS:

- NONE
 ONE
 TWO
 THREE

7. HAS CLIENT EVER HAD CAROTID ARTERY SURGERY AS THE RESULT OF A STROKE?

NO YES, DATE: MONTH _____ YEAR _____

RESULTS _____

8. AS A RESULT OF THE STROKE, DOES CLIENT HAVE ANY RESIDUAL NEUROLOGICAL DEFICITS?

- NONE
 SLURRED SPEECH
 LOSS OF USE, OR RESTRICTED LIMB MOVEMENT
 OTHER IMPAIRMENT:

9. APPROXIMATE DATE OF THE LAST STRESS TEST:

- WITHIN THE LAST 6 MONTHS
 6 MONTHS TO A YEAR AGO
 MORE THAN A YEAR AGO

RESULTS _____

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