BackNine Insurance

QUICK QUOTE FOR MULTIPLE SCLEROSIS

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

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, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____

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 _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____/_____ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. DATE MULTIPLE SCLEROSIS WAS DIAGNOSED _____

2. IS MULTIPLE SCLEROSIS ACTIVE?
❑ NO ❑ YES

WHAT IS THE DATE OF THE LAST ATTACK _____

3. PLEASE LIST CURRENT MEDICATIONS:
_____

_____

4. WHAT IS THE DEGREE OF SEVERITY OF M.S.?
❑ MILD - TOTAL 2 TO 4, MILD EXACERBATIONS WITH NO RESIDUALS

❑ MODERATE -SLOWLY PROGRESSIVE, ONE OR TWO ATTACKS PER YEAR WITH RECOVERY BETWEEN ATTACKS, SOME MODERATE RESIDUALS, SUCH AS CANE USE

❑ SEVERE - PROGRESSIVE, MORE THAN 2 ATTACKS PER YEAR, WHEEL CHAIR CONFINEMENT, BEDRIDDEN

❑ RAPIDLY PROGRESSING SYMPTOMS

5. CURRENT SYMPTOMS (CHECK ALL THAT HAVE OCCURRED OVER THE **PAST TWO YEARS):**
❑ VISUAL DIFFICULTIES
❑ NUMBNESS
❑ WEAKNESS OR FATIGUE
❑ IMPAIRED SWALLOWING
❑ FREQUENT BLADDER INFECTIONS
❑ BOWEL CONTROL DIFFICULTIES
❑ USE OF CANE
❑ USE OF WHEEL CHAIR
❑ DIFFICULTY WITH SPEECH

6. 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

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:
_____

_____

_____