BackNine Insurance

QUICK QUOTE FOR PARALYSIS AND SPINAL CORD INJURY

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. WHAT CAUSED THE PARALYSIS?

❑ TRAUMA, GIVE DETAILS AND DATE OF OCCURRENCE

_____

❑ SURGERY, DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE

_____

_____

❑ STROKE OR CEREBRAL VASCULAR ACCIDENT

❑ 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 VERTEBRAE IF AVAILABLE, C7-8, FOR EXAMPLE):

❑ 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 ASSISTANCE EATING
❑ NEEDS ASSISTANCE TO COMMUNICATE

6. IS TREATMENT CURRENTLY BEING PRESCRIBED?

❑ NO ❑ YES, PLEASE DETAIL _____

_____

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:

_____

_____

_____