

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor **Type of Coverage:** Term UL Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of the transplant: _____

2. Single or multiple transplant?

3. What was the cause of the end stage renal disease which led to the transplant? (Cause for the transplant)

Diabetes Glomerulonephritis Nephrosclerosis Systemic lupus erythematosus

Polycystic kidney disease Other: _____

4. What was the source of the donor kidney?

Cadaver Living related donor Identical twin Other: _____

5. Please give most recent results of kidney function tests:

BUN _____

Serum creatinine _____

Urinalysis _____

6. Have any of the following occurred (check all that apply):

Frequent infection Rejection episodes Toxicity from treatment High blood pressure

Cardiovascular disease Cancer Disease recurrence

7. How often are checkups? _____

8. Are there any disabilities since the transplant? No Yes; please give details

9. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Does client have any other major health issues? (additional questionnaires may be required) No Yes; please give details