BB&G © QUICK QUOTE FOR KIDNEY TRANSPLANTS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 _____

AMNT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS.: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL _____ / REPLACEMENT? [ ] YES [ ] NO / CURRENT ANN. PREMIUM $ _____

LAST LIFE INSURANCE APP.: YEAR _____ COMPANY _____ ACTION _____

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

FOR USE BY CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. WHAT DISORDER MADE THE KIDNEY TRANSPLANT NECESSARY?

[ ] KIDNEY FAILURE DUE TO DIABETES
[ ] KIDNEY FAILURE DUE TO GLOMERULONEPHRITIS
[ ] KIDNEY FAILURE DUE TO POLYCYSTIC KIDNEY DISEASE
[ ] OTHER CAUSES, PLEASE SPECIFY _____

2. DATE OF THE TRANSPLANT _____

3. SOURCE OF THE TRANSPLANTED KIDNEY:

[ ] IDENTICAL TWIN
[ ] RELATED DONOR WITH IDENTICAL HLA PHENOTYPIC MATCH
[ ] RELATED DONOR WITHOUT IDENTICAL HLA PHENOTYPIC MATCH
[ ] NON-RELATED LIVE DONOR
[ ] NON-RELATED CADAVER KIDNEY

4. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS?

[ ] YES [ ] NO IF YES, PLEASE GIVE DETAILS _____

_____

5. PLEASE GIVE RESULTS OF MOST RECENT KIDNEY FUNCTION TESTS:

BUN _____

SERUM CREATINE _____

URINALYSIS _____

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

[ ] FREQUENT INFECTION
[ ] REJECTION EPISODES
[ ] HIGH BLOOD PRESSURE
[ ] CARDIOVASCULAR DISEASE
[ ] TOXICITY FROM TREATMENT
[ ] CANCER
[ ] DISEASE RECURRENCE

7. WHAT TREATMENT IS CURRENTLY BEING PRESCRIBED?

LIST MEDICATIONS AND DOSAGE _____

_____

8. WHEN WAS THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOWUP ON THE TRANSPLANT?

_____

9. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

_____

10. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

11. CLIENT'S OCCUPATION _____

12. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

_____

_____

_____

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