BackNine Insurance

QUICK QUOTE FOR KIDNEY TRANSPLANTS

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 DISORDER MADE THE KIDNEY TRANSPLANT NECESSARY?

❑ KIDNEY FAILURE DUE TO DIABETES
❑ KIDNEY FAILURE DUE TO GLOMERULONEPHRITIS
❑ KIDNEY FAILURE DUE TO POLYCYSTIC KIDNEY DISEASE

❑ OTHER, PLEASE SPECIFY _____

2. DATE OF THE TRANSPLANT _____

3. SOURCE OF THE TRANSPLANTED KIDNEY:

❑ IDENTICAL TWIN
❑ RELATED DONOR WITH IDENTICAL HLA MATCH
❑ RELATED DONOR W/O IDENTICAL HLA MATCH
❑ NON-RELATED LIVE DONOR
❑ NON-RELATED CADAVER KIDNEY

4. ARE THERE ANY CURRENT SYMPTOMS / COMPLICATIONS?

❑ NO ❑ YES, PLEASE GIVE DETAILS _____

_____

5. 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. 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:

_____

_____

_____