

QUICK QUOTE Kidney Transplants



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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. © COPYRIGHT LifeBrokers.

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, AGE AND CAUSE, OF EACH _____
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. PLEASE NOTE DISORDER THAT MADE THE KIDNEY TRANSPLANT NECESSARY:

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

OTHER, PLEASE DETAIL _____

2. DATE OF THE TRANSPLANT _____

3. SOURCE OF THE TRANSPLANT KIDNEY:

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

4. ARE THERE ANY CURRENT SYMPTOMS/COMPLICATIONS?

NO YES, DETAILS _____

5. GIVE RESULTS OF MOST RECENT KIDNEY FUNCTION TESTS:

BUN _____

SERUM CREATINE _____

URINALYSIS _____

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

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

7. PLEASE DETAIL ANY CURRENT TREATMENT PRESCRIBED:

8. DATE OF THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOW UP 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):
