

# Underwriting Questionnaire

## Kidney Transplant

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.

Term  Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Date(s) of transplant(s) \_\_\_\_\_

Cause of the end stage renal disease which led to the transplant

- Diabetes  Polycystic kidney disease  
 Glomerulonephritis  Systemic lupus erythematosus  
 Nephrosclerosis  Other \_\_\_\_\_

Source of the donor kidney

- Cadaver  Living donor  
 Identical twin  Living related donor

Most recent kidney function test results

BUN \_\_\_\_\_ Serum creatinine \_\_\_\_\_  
 GFR \_\_\_\_\_ Urinalysis \_\_\_\_\_

Select all that have occurred

- Cancer Date \_\_\_\_\_ Details \_\_\_\_\_  
 Cardiovascular disease Date \_\_\_\_\_ Details \_\_\_\_\_  
 Disease recurrence Date \_\_\_\_\_ Details \_\_\_\_\_  
 Frequent infection Date \_\_\_\_\_ Details \_\_\_\_\_  
 High blood pressure Date \_\_\_\_\_ Details \_\_\_\_\_  
 Rejection episodes Date \_\_\_\_\_ Details \_\_\_\_\_  
 Toxicity from treatment Date \_\_\_\_\_ Details \_\_\_\_\_

Date of last appointment with Nephrologist \_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: