



# INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

## *Kidney Transplant Questionnaire*

**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.**

**Agent's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
**Proposed Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_  
**Male ( ) Female ( ) Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Smoker ( ) Non Smoker ( )**  
**Amount of Coverage \$** \_\_\_\_\_ **Product Type** \_\_\_\_\_

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 follow-up 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: \_\_\_\_\_  
\_\_\_\_\_