CPS INSURANCE SERVICES

QUICK QUOTE FOR KIDNEY TRANSPLANTS

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, PROVIDE RELATION, AGE AND CAUSE OF DEATH ____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET____

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 ____________ RESULTS ____

DATE OF LAST RESTING EKG ________________ RESULTS____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____________/ ARE YOU TREATED FOR BLOOD PRESSURE? ☐ NO ☐YES

LAST TOTAL CHOLESTEROL READING AND HDL READING ________________/ARE YOU TREATED FOR CHOLESTEROL? ☐ NO ☐YES

AGENT: NAME ____ PHONE _______________________ FAX ____________________

ADDRESS ____ CITY _________________________ ST ______ ZIP ____________

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION ____ FAX ____________________

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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 ______________________________

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5. GIVE RESULTS OF MOST RECENT KIDNEY FUNCTION TESTS:

BUN _________ CREATININE _____________________

URINARY PROTEIN ________ GFR______________

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:

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

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9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS TAKEN:

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