GLOMERULONEPHRITIS

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please note type of Glomerulonephritis: _____

2. Please list date of first diagnosis: _____

3. Was a kidney biopsy done? ☐ No ☐ Yes; please give date and diagnosis

_____

_____

4. Please provide the client's most recent readings for:

☐ Blood pressure _____

☐ BUN _____

☐ Creatinine _____

☐ Urinalysis _____

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Does client have any other major health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

