



Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of birth: _____

Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(1) Has the proposed insured been diagnosed with PKD? Yes No

(2) If (1) is yes, please provide date of diagnosis: _____

(3) Please provide approximate dates and readings of known blood pressure measurements:

Approximate date(s):	Systolic/Diastolic reading(s):	Approximate date(s):	Systolic/Diastolic reading(s):

(4) Please advise of the following laboratory findings, if previously (and recently) done by your physician?

Laboratory findings of:	Date of most recent test:	Level of findings:	Normal reference range:
Protein in the urine (proteinuria):			
Blood in the urine (hematuria):			
Blood urea nitrogen (BUN) level:			
Creatinine level:			

(5) Does the proposed insured take any medications? If yes, please list:

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

(6) Is there any known history of cardiovascular impairment? Yes No

If yes, please advise what has been diagnosed and when: _____

(7) Is there any known family history relating to kidney/cardiovascular disease? If yes, please describe:

	Age (if living)	Age (at death)	Cause of death, if deceased:	History of kidney disease?	History of heart disease or circulatory disorder?	History of stroke?
Mother				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sister(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brother(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No