

APPLICATION FOR TRANSPLANT PROCEDURES RIDER

To be completed by the policyholder
(PLEASE USE BLOCK LETTERS)



1. POLICYHOLDER'S INFORMATION

Name	Last	First	M.I
Policy number			

2. MEDICAL HISTORY

Please indicate if any of the applicants has, ever had, or has been diagnosed with or treated for any of the following:

1	Vision disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Convulsions (seizures) or other neurological disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Heart disorders, shortness of breath, rheumatic fever, cardiac defects or any other cardiovascular disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Pulmonary disease, emphysema, or any other respiratory problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Disease of the pancreas, esophagus, stomach, intestines, liver, or any other digestive disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6	Kidney disorders, calculus, albumin or blood in urine, bladder disorders, or any other urinary tract disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	Musculoskeletal disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	Cancer or tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	Anemia, leukemia, lymphoma, disorders of the spleen or lymph nodes, or any other blood disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10	Diabetes or any other endocrine disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11	Disorders of the reproductive organs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12	Disorders of the breasts, ovaries, uterus, fallopian tubes, or any other gynecological disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13	Skin disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14	Congenital or hereditary disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15	Any sickness, injury, accident, or defect not mentioned above	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16	Any organ, cell, or tissue transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17	Been recommended to have an organ, cell, or tissue transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide details about any affirmative answer:

#	Name of applicant		Condition, surgery, or treatment
	Last	First	M.I.
From date	To date	Name of physician and hospital	Telephone
MM / DD / YY	MM / DD / YY		
#	Name of applicant		Condition, surgery, or treatment
	Last	First	M.I.
From date	To date	Name of physician and hospital	Telephone
MM / DD / YY	MM / DD / YY		
#	Name of applicant		Condition, surgery, or treatment
	Last	First	M.I.
From date	To date	Name of physician and hospital	Telephone
MM / DD / YY	MM / DD / YY		
#	Name of applicant		Condition, surgery, or treatment
	Last	First	M.I.
From date	To date	Name of physician and hospital	Telephone
MM / DD / YY	MM / DD / YY		

3. APPLICANT'S SIGNATURE

I hereby certify to the best of my knowledge that I have read and reviewed all the answers and declarations in this application, and that they are true and correct. Any omission or incorrect/incomplete statement could cause the denial of claims. I understand that the term "applicant" applies to all members under the policy.

Date	MM / DD / YY	Signature	
Date	MM / DD / YY	Spouse's signature	