# 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 | ☐ Yes | ☐ No |
| 2 | Convulsions (seizures) or other neurological disorders | ☐ Yes | ☐ No |
| 3 | Heart disorders, shortness of breath, rheumatic fever, cardiac defects or any other cardiovascular disorders | ☐ Yes | ☐ No |
| 4 | Pulmonary disease, emphysema, or any other respiratory problems | ☐ Yes | ☐ No |
| 5 | Disease of the pancreas, esophagus, stomach, intestines, liver, or any other digestive disorders | ☐ Yes | ☐ No |
| 6 | Kidney disorders, calculus, albumin or blood in urine, bladder disorders, or any other urinary tract disorders | ☐ Yes | ☐ No |
| 7 | Musculoskeletal disorders | ☐ Yes | ☐ No |
| 8 | Cancer or tumors | ☐ Yes | ☐ No |
| 9 | Anemia, leukemia, lymphoma, disorders of the spleen or lymph nodes, or any other blood disorders | ☐ Yes | ☐ No |
| 10 | Diabetes or any other endocrine disorders | ☐ Yes | ☐ No |
| 11 | Disorders of the reproductive organs | ☐ Yes | ☐ No |
| 12 | Disorders of the breasts, ovaries, uterus, fallopian tubes, or any other gynecological disorders | ☐ Yes | ☐ No |
| 13 | Skin disorders | ☐ Yes | ☐ No |
| 14 | Congenital or hereditary disorders | ☐ Yes | ☐ No |
| 15 | Any sickness, injury, accident, or defect not mentioned above | ☐ Yes | ☐ No |
| 16 | Any organ, cell, or tissue transplant | ☐ Yes | ☐ No |
| 17 | Been recommended to have an organ, cell, or tissue transplant | ☐ Yes | ☐ 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 / YYYY | MM / DD / YYYY | | |
| | | | |
| # | Name of applicant | | Condition, surgery, or treatment |
| | Last First M.I | | |
| From date | To date | Name of physician and hospital | Telephone |
| MM / DD / YYYY | MM / DD / YYYY | | |
| | | | |
| # | Name of applicant | | Condition, surgery, or treatment |
| | Last First M.I | | |
| From date | To date | Name of physician and hospital | Telephone |
| MM / DD / YYYY | MM / DD / YYYY | | |
| | | | |
| # | Name of applicant | | Condition, surgery, or treatment |
| | Last First M.I | | |
| From date | To date | Name of physician and hospital | Telephone |
| MM / DD / YYYY | MM / DD / YYYY | | |
| | | | |

## 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 / YYYY | Signature | |
| Date | MM / DD / YYYY | Spouse's signature | |