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	