

APPLICANT INFORMATION

Name	Date of Birth	Ht	Wt
A. Proposed Insured	-----		
B. Spouse			
C. Child			
D. Child			
E. Child			

MEDICAL INFORMATION

I. Please indicate if any person to be insured has ever been treated for or diagnosed by a physician or practitioner as having any of the following. Underline any specific condition below.

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|--|--|---|
| 1. Adrenal/Pituitary Disorders | 14. Currently Pregnant | 30. Lupus |
| 2. Acquired Immune Deficiency/
AIDS Related Complex | 15. Diabetes | 31. Lymphatic Disorder |
| 3. Alcohol Addiction/Abuse | 16. Diagnostic Testing | 32. Surgery within last 5 years |
| 4. Aneurysm/Stroke | 17. Dizziness/Loss of Consciousness | 33. Mental Illness/Emotional
Disorder |
| 5. Asthma/Chronic Bronchitis | 18. Drug Addiction/Abuse | 34. Neurological Disorders/M.S. |
| 6. Arthritis/Gout/Joint Disorder | 19. Epilepsy/Seizures/Convulsions | 35. Pancreatitis |
| 7. Back Disorder | 20. Reproductive/Breast Disorders | 36. Paralysis/Polio Residuals |
| 8. Birth Defects/Congenital
Abnormality | 21. GI Disorder/Ulcer/Crohn's | 37. Proctitis/Rectal Disorder |
| 9. Blood Disorder/Transfusion/
Hemorrhage | 22. Gonorrhea/Syphilis | 38. Respiratory/Tuberculosis |
| 10. Cancer/Leukemia/Hodgkins | 23. Headaches | 39. TMJ Disorder |
| 11. Circulatory/Vascular Disorder | 24. Heart Disease, Disorder/Angina | 40. Thyroid/Goiter |
| 12. Colitis | 25. High Blood Pressure | 41. Tumor/Abscess/Cyst |
| 13. Complications of Pregnancy | 26. Immunodeficiency Disorder | 42. Varicose Veins |
| | 27. Kidney/Bladder/Prostate Disorder | 43. Vision/Hearing Disorders |
| | 28. Liver Disorder/Hepatitis/Cirrhosis | 44. Any Other Health Conditions
Not Listed |
| | 29. Lung Disorder/Respiratory | |

II. Any Other Medical Treatment Recommended but NOT YET COMPLETED: _____

III. I have reviewed all of the above medical conditions and believe my answers to be complete. (Please initial) _____

IV. Give details to all answers. Indicate below: name of person; dates and condition code number(s) of treatment; diagnoses; duration; outcomes; and names and addresses of all attending physicians and medical facilities. If necessary use a separate sheet of paper, dated and signed.

V. In the spaces below, indicate all physicians visits in the last 5 years. Include physician's name and address, dates, reasons and results of each visit. In space a., please name the physician who is most likely to have your complete medical records.

Patient's Name	Physician's Name and Address	Dates	Reasons (code #)	Results
a.				
b.				
c.				
d.				
e.				

VI. Are you currently, actively at work and able to perform the duties of your occupation? Yes No

VII. Are you covered by Workers' Compensation? Yes No

REMARKS

