HEALTH INFORMATION QUESTIONS

Employer name____

Employee	Sex: ☐ Male ☐ Female	Birthdate (mo/day/year)	Age	Height	Weight
Spouse	☐ Wife ☐ Husband				
Dependent Children	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				

1. Have you or any eligible dependent(s) ever had, been told you had, or been treated for any of the following:

a. Heart/Circulatory Disorder? ☐ Yes ☐ No
b. High Blood Pressure? ☐ Yes ☐ No
c. Mental/Nervous, Emotional Disorders? ☐ Yes ☐ No
d. Alcoholism and/or Nerve Disorders? ☐ Yes ☐ No
e. Stomach and/or Intestinal Disorder? ☐ Yes ☐ No
f. Multiple Sclerosis or Nerve Disorder? ☐ Yes ☐ No
g. Stroke/Paralysis? ☐ Yes ☐ No
h. Cancer, Tumors? ☐ Yes ☐ No
i. Kidney Disorder? ☐ Yes ☐ No
j. Liver Disorder? ☐ Yes ☐ No
k. Gland Disorder? ☐ Yes ☐ No
l. Diabetes? ☐ Yes ☐ No
m. Developmental Disorder? ☐ Yes ☐ No
n. Epilepsy, Seizures? ☐ Yes ☐ No
o. Lung, Respiratory Disorder? ☐ Yes ☐ No
p. Bone, Joint, Muscle Disorder? ☐ Yes ☐ No
q. Severe Accident or Injury? ☐ Yes ☐ No
r. Blood Disorder? ☐ Yes ☐ No

2. Are you or any eligible dependent(s) currently receiving or recommended to receive medication or treatment? ☐ Yes ☐ No

3. Are you or any eligible dependent(s) currently pregnant? ☐ Yes ☐ No

4. Have you or any eligible dependent(s) ever:

a. Had an electrocardiogram, x-ray, or other special test? ☐ Yes ☐ No

b. Consulted, been treated or examined by any physician or practitioner during the past 5 years for any reason not mentioned previously? ☐ Yes ☐ No

c. Have had a surgery or advised to have a surgery in the past 5 years? ☐ Yes ☐ No

d. Been declined or due to a health condition, received higher rates or had special conditions applied for Life, Major Medical, or Accident and Sickness Insurance? ☐ Yes ☐ No

e. Been confined to a hospital, sanitarium, or similar institution in the last 5 years? ☐
Yes ☐ No

If any of the above questions is answered YES, on the reverse side state: Question number, name of person, detail of illness or accident, cost of expenses, date last treated for condition, the name of the physician and the city where treated.

PLEASE SIGN AND DATE WHERE INDICATED ON THE BACK OF THIS FORM

Question Number	Name of Person	Details/Diagnosis of Illness or Accident	Total of Expenses in the Past 5 Years	Date Last Treated for Condition	Full Name and City and Phone Number for Doctor(s), Hospital(s) Where Treated

I authorize and direct any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my dependents' health to provide any such information as requested. A photocopy of this authorization will operate as an original.

I hereby represent that I have read the foregoing application, including all questions and the respective answers, and that the conditions and health history of myself and members of my family are as above states.

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DEFECTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Signature of Applicant____

Signed at City____________________________ **State**________________ **Date**______________________