

Health Questionnaire

This form is part of the Application for Life Insurance for the Proposed Life Insured.
 Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

PROPOSED LIFE INSURED

1. a) Name _____ b) Date of Birth _____
- First Middle Last
- month day year
- c) Gender Male Female

SMOKING STATUS

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, shisha, nicotine patches or gum)?
- Yes No If 'Yes', provide details below.

Product:	Frequency:	Current	Past	Date Last Used		
				month	day	year
Cigarettes	_____ pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

FAMILY QUESTIONS

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? Yes No
4. Please provide the following details.

Living			Deceased		
	Age	Give Details of Present State of Health		Age	Cause of Death
Father			Father		
Mother			Mother		
Brothers and Sisters			Brothers and Sisters		

5. a) Name and Address of Personal or Attending Physician

First _____ Middle _____ Last _____

Street No. & Name _____ Suite No. _____ City _____ State _____ Zip code _____

b) Telephone No. _____

c) Date last consulted Reason for consultation Diagnosis/Result of visit

month day year

d) List any medications (prescription or nonprescription) you are taking currently

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

1. The Company to obtain an investigative consumer report on me.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, or any other similar person or organization to give The Company and its reinsurers information about me or any minor child who is to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

I further authorize The Company to disclose such information and any information developed during its evaluation of this application to: (a) its reinsurers; (b) other insurance companies as designated by me; (c) me; (d) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (e) any medical professional designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

SIGNATURES

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief.

I hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at City Country This Day of Year

Signature of Proposed Life Insured

X

I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Life Insured.

Signature of Financial Representative

Print Name of Financial Representative

X