

HEALTH STATEMENT

To determine if you're eligible for this hospital confinement and surgical fixed indemnity insurance plan, you need to answer a few medical questions for you and anyone else applying for this plan.

Attach a separate sheet if additional information is needed. Date and sign any additional sheets.

Note: The plan cannot be issued to any person who answers YES to any of the following questions.

Enter dependent information in same order as page 1.

		Primary	Spouse	A.	B.	C.	D.
9. Are you, your spouse or any person to be insured now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you, your spouse or any person to be insured totally and permanently disabled and/or receiving long-term disability benefits?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/ Ventricular Septal Defect (VSD) • Stroke or Brain Aneurysm • Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) • Crohn's Disease or Ulcerative Colitis • Liver disorders, excluding fully recovered Hepatitis A • Kidney disorders, excluding kidney stones • Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension 	<ul style="list-style-type: none"> • Diabetes, excluding Gestational Diabetes • Basal Cell Carcinoma with recommended surgery that has not been completed • Cancer or Tumor • Alcoholism, Alcohol or Chemical Dependency or Drug or Alcohol Abuse • Multiple Sclerosis (MS) • Tuberculosis (TB) • Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss • Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Developmental Disorders or Pervasive Developmental Delay 						
12. For any of the following conditions within the last 5 years, have you or any person to be insured tested positive for, or received any medical or surgical treatment or taken medication for:	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) 							

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020