

HEALTH APPLICATION FORM

| APPLICANT'S PERSONAL INFORMATION | | | | | | | | | | |
|----------------------------------|------|----|-----------|-----|---------------|------|------|-----|--------|--------|
| | Name | I. | Last name | Sex | Date of Birth | | | Age | Height | Weight |
| | | | | | Day | Mth. | Year | | | |
| Main | | | | | | | | | | |
| Spouse | | | | | | | | | | |
| Child | | | | | | | | | | |
| Child | | | | | | | | | | |
| Child | | | | | | | | | | |
| Child | | | | | | | | | | |
| Child | | | | | | | | | | |
| Child | | | | | | | | | | |

| | | |
|---|-------------------------------|--------------------------|
| Permanent Residence(Including City and State): | Mailing address: | Telephone number: |
| | | |
| | Email: | Fax: |
| Employer or other postal address: | Occupation and duties: | Telephone number: |
| | | |
| | Email: | |

| | Applicant | Optional Coverage* | Premium |
|---|-----------|--------------------|---------|
| 1 | | | \$ |
| 2 | | | \$ |
| 3 | | | \$ |
| 4 | | | \$ |
| 5 | | | \$ |

| | |
|---|--|
| <p style="text-align: center;">MODE OF PAYMENT</p> <p> <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Credit Card <input type="checkbox"/> Cheque <input type="checkbox"/> Wire Transfer <small>\$10.00 fee applies for wire transfer</small> </p> | <p>Deductible</p> <p>Plan:</p> |
|---|--|

| |
|------------------------|
| Annual Premium: |
| Monthly (x0.092+ \$2): |
| Semi Annual (x0.55): |

| |
|--|
| For company use only: |
| Policy Number: <div style="border: 1px solid black; width: 150px; height: 30px; display: inline-block; vertical-align: middle;"></div> |

| 1 | HAS ANY APPLICANT PROPOSED FOR COVERAGE EVER BEEN ADVISED TO OR RECEIVED MEDICAL CONSULTATION, CARE, TREATMENT OR TAKEN MEDICATION FOR: (Please circle each condition) | Yes | No |
|-----------|---|-----|----|
| a. | Heart or circulatory system (including but not limited to infarction, high blood pressure, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins or arteries) and/or any other symptom regarding the circulatory system or heart, which if referred to a doctor would result in a diagnosis. | | |
| b. | Respiratory system (including but not limited to deviated septum, sinusitis, polyps or cyst, asthma, bronchitis, emphysema, bronchiectasis, tuberculosis) and/or any other symptom regarding the respiratory system, which if referred to a doctor would result in a diagnosis. | | |
| c. | Gastrointestinal system (including but not limited to gastro esophageal reflux, hiatal hernia, gastritis, gastric or duodenal ulcer, duodenitis, diverticulosis, diverticulitis, polyps, colitis, gallbladder diseases) and/or any other symptom regarding the gastrointestinal system, which if referred to a doctor would result in a diagnosis. | | |
| d. | Urinary system (including but not limited to kidney diseases, stones, infections, urinary tract disease, bladder disorders, and prostate diseases) and/or any other symptom regarding the urinary system, which if referred to a doctor would result in a diagnosis. | | |
| e. | Musculoskeletal system (including but not limited to back disorders, spinal cord disorders, rheumatism, arthritis/arthrosis, gout, lumbago, osteoporosis, deformity, herniated disc) and/or any other symptom regarding the musculoskeletal system, which if referred to a doctor would result in a diagnosis. | | |
| f. | Neoplastic disorders, benign or malignant tumors (cancer) | | |
| g. | Endocrine system (including but not limited to Hypophysis gland diseases, Thyroid, Parathyroid, Diabetes, Ovaries and Adrenal glands disorders) and/or any other symptom regarding the endocrine system, which if referred to a doctor would result in a diagnosis. | | |
| h. | Sexually transmitted diseases or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex). | | |
| i. | Female reproductive system (including but not limited to disorders of menstrual cycle, ovaries, uterus including cervix, endometriosis, pelvic inflammatory diseases, fallopian tubes, vagina, miscarriages, cesarean section). Breast disorders (including but not limited to fibrocystic diseases, tumor) and/or any other symptom regarding the female reproductive system or breast, which if referred to a doctor would result in a diagnosis. | | |
| j. | Male reproductive system (including but not limited to prostate, testes, and penis) and/or any other symptom regarding the male reproductive system, which if referred to a doctor would result in a diagnosis. | | |
| k. | Neurological system (including but not limited to convulsions, epilepsy, paralysis, Multiple Sclerosis, cerebral infarction, Alzheimer's disease, Dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis. | | |
| l. | Liver disorders (including but not limited to fatty liver, Cirrhosis, Hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis. | | |
| m. | Any skin disorders (including but not limited to acne, psoriasis, melanomas, and carcinomas). | | |
| n. | Hematologic and Lymphatic system (including but not limited to anemia, leukemia, multiple myeloma, Waldenstrom's Macroglobulinemia, Spleen's disorders and other blood and coagulation disorders) and/or any other symptom regarding the Hematologic and Lymphatic system, which if referred to a doctor would result in a diagnosis. | | |
| o. | Collagen's diseases (including but not limited to Rheumatoid Arthritis, Systemic Lupus Erythematosus, Scleroderma) and/or any other symptom regarding collagen diseases, which if referred to a doctor would result in a diagnosis. | | |
| 2. | HAS ANY PERSON PROPOSED FOR COVERAGE: | | |
| a. | Had health examinations or routine medical check-ups? Any abnormalities? | | |
| b. | Been a patient in a hospital, clinic or sanatorium? | | |
| 3. | IS ANYONE WHO IS APPLYING FOR COVERAGE, PREGNANT? | | |
| 4. | HAS ANYONE PROPOSED FOR COVERAGE BEEN RECOMMENDED TO UNDERGO A SURGERY THAT IS STILL PENDING? | | |
| 5. | IS ANYONE CURRENTLY TAKING ANY PRESCRIBED MEDICATION OR UNDER MEDICAL TREATMENT OR HAS BEEN ADVISED OF FUTURE TREATMENTS? | | |
| 6. | HAS OR IS ANYONE BEEN ADDICTED TO DRUGS OR ALCOHOL, HAS OR IS ANYONE EVER USED DRUGS NOT PRESCRIBED BY A PHYSICIAN? HAS OR IS ANYONE BEEN UNDER A REHABILITATION PROGRAM FOR ADDICTION OR SUBSTANCE ABUSE? | | |
| 7. | RECEIVED TREATMENT OR HAS BEEN DIAGNOSED FOR ANY DISORDERS, CONDITIONS OR IS TAKING PRESCRIBED MEDICATION FOR ANY CONDITION NOT MENTIONED ABOVE? | | |
| 8. | HAS ANY PERSON ON WHOM COVERAGE IS REQUESTED BEEN DECLINED, POSTPOSED OR RATED IN ANY WAY? Please give details. | | |
| 9. | HAS ANY PERSON ON WHOM COVERAGE IS REQUESTED BEEN INVOLVED IN THE OPERATION OF AN AIRCRAFT OR INVOLVED IN ANY HAZARDOUS SPORT? Please give details. | | |

MAIN INSURED SIGNATURE: _____

INITIALS: _____

