

APPLICATION TO ADD A DEPENDENT

Name of Insured:				POLICY No.			RATE:			
1.- Requester's Name:		Relationship to Insured	Birth Date	Height	Weight	Age	Sex	Place of Birth	Passport or ID Number	
Last	M. First									

ADDITIONAL INFORMATION ABOUT APPLICANTS

2.- Do you suffer, have suffered, or are under treatment for any of the following afflictions?

	YES	NO		YES	NO
a. Asthma, emphysema, bronchitis or other disease of affliction of the respiratory system?	Z	Z	h Any other disease, injuries, surgeries or deformities?	Z	Z
b. High blood pressure, chest pains, inflammation of the feet, heart attacks, lack of breath or other disease or affliction of the heart or circulatory system?	Z	Z	i. Women:		
			a) Any complication with maternity, past or present?	Z	Z
c. Fainting, epilepsy, seizures, injuries in the head or other disease or affliction in the brains or the nervous system?	Z	Z	b) Are you presently pregnant?		
			j. Date of last medical exam:	Z	Z
d. Albumin or blood in the urine; diabetes or other disease or other disease or affliction of the kidneys, bladder or prostate?	Z	Z	k Were you born with some complication, deformity or congenital disease?	Z	Z
e. Cancer or other tumors?	Z	Z	l. Acquired Immuno Deficiency Syndrome (AIDS) or the Complex Syndrome related to AIDS (SCRS), or diseases caused by or related to positive HIV, or venereal diseases of any kind?	Z	Z
f. Any diseases or affliction of the stomach, colon, liver or digestive system?	Z	Z		Z	Z
g. Any disease or affliction of the muscles, bones or joints?	Z	Z		Z	Z

PLEASE PROVIDE ALL DETAILS OF AFFIRMATIVE ANSWERS IN QUESTION 2:

Name of Person and Question Number	Conditions and Complications Indicate if Surgery	Beginning Date	Duration	Names and Addresses of Doctor and Hospitals

3.- To the best of your knowledge and belief.

- a. Have you been arrested or received treatment due to use of drugs or alcohol?
- b. Have you been consulted or examined, or are you under treatment of a physician, psychiatrist or psychologist?
- c. Have you participated or are considering to participate in any dangerous activity or sports, such as aviation, scuba diving or auto racing?
- d. Does any of the persons proposed for insurance reside in another place? Indicate name, address and reason.

YES NO

Z Z
Z Z
Z Z
Z Z

Please detail all affirmative answers below:

Signed in _____

Date _____

Signature _____
Agent

Signature _____
Applicant

Signature _____
Requester (If the Dependant is Applying)