

PART 3 INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING PROGRAM – If you are part of the Simplified Underwriting Program please complete Section A and skip to Part 4. If you are part of the full underwriting program please complete all Parts of the application.

Section A

- ♦ Please check “yes” or “no” to each question. If “yes”, circle all diagnoses or conditions that apply.
- ♦ If you answer “yes” to any question 1-6, then we suggest you do not submit an application. We will be unable to offer you coverage.

	Applicant A	Applicant B
1 Do you have or have you ever been diagnosed for:		
<ul style="list-style-type: none"> ♦ Alzheimer’s Disease ♦ ALS (Lou Gehrig’s Disease) ♦ Cirrhosis ♦ Chronic Kidney Failure ♦ Dementia ♦ Diabetes –treated with greater than 49 units of insulin or with amputation or ongoing complications affecting the kidney ♦ Memory Loss ♦ Mental Retardation ♦ Metastatic Cancer ♦ Multiple Sclerosis ♦ Muscular Dystrophy ♦ Neurological Conditions affecting the Brain or Spinal Cord ♦ Organic Brain Syndrome ♦ Parkinson’s Disease ♦ Paralysis ♦ Post Polio Paralytic Syndrome ♦ Schizophrenia ♦ Scleroderma ♦ Systemic Lupus Erythematosus ♦ Stroke/CVA ♦ TIA’s 2 or more 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Do you currently use one of the following medical devices: wheelchair; walker; hospital bed; quad cane; oxygen; stairlift; or dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Are you currently receiving Social Security Disability, Worker’s Compensation or Long Term Disability Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SAMPLE

Section B

If you are part of the Simplified Underwriting Program please skip to Part 4.

MEDICAL HISTORY	Applicant A	Applicant B
1 Have you consulted with your Primary Care Physician within the last 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant A: Primary Care Physician Name: _____ Address: _____ City, State, Zip Code: _____ Tel. #: _____ Date Last Seen: _____	Applicant B: Primary Care Physician Name: _____ Address: _____ City, State, Zip Code: _____ Tel. #: _____ Date Last Seen: _____	