Disclaimer: Not an application for life insurance. This inquiry is exclusively for specific information on a proposed insured's medical history and other factors that my affect underwriting and rating classification.

INSURED **INFORMATION**

Date: ___________________

Name: ____ Date of Birth __________________________

Height ___________ Weight __________ Sex: ❑ M ❑ F Social Security or Tax ID Number ________________________

1. Any weight change of 10 lbs. or more in the last year? ❑ Yes ❑ No If yes, how much? Reason? ___________________
2. Tobacco or nicotine use of any form (cigarette, cigar, chew, gum, etc.?) ❑ Yes ❑ No
   If yes, type, quantity, and frequency? ____
   If insured quit using tobacco, how long ago? ____
3. I am a resident of the state of ______________________
4. Do you plan any foreign travel or residency outside of the U.S. or Canada in the next two years? ❑ Yes ❑ No
   If yes, where to and for how long? ____
5. Have you traveled outside of the U.S. or Canada in the past three years? ❑ Yes ❑ No
   If yes, provide details ____
6. In the past two years, have you flown as a pilot or co-pilot? ❑ Yes ❑ No
7. Are you involved in any potentially hazardous or dangerous hobbies (ballooning, boxing, diving, white water rafting, rodeo events, racing, hang gliding, parachuting, etc.?) ❑ Yes ❑ No If yes, please indicate _________________________
8. When operating a motor vehicle, boat, or aircraft in the last three years, have you:
   A. Been convicted of any moving violations? ❑ Yes ❑ No
   B. Had an operator's license restricted, suspended, or revoked? ❑ Yes ❑ No
   C. Been convicted of operating under the influence of alcohol or drugs? ❑ Yes ❑ No
   Please provide details for any "yes" responses: ____
   ____
9. List current medications, including dosage and frequency: ____
   ____
   ____
10. Who is your primary care physician? (name, address, phone number): ____
    ____
11. List all other medical doctors seen in the last five years (name, address, phone number): ______________________________
    ____
    ____
12. Current blood pressure an date it was last taken: ____
13. Total Cholesterol Level: ________________ HDL:_____________ LDL: ______________ Chol/HDL:_____________
14. Have you ever been diagnosed with cancer? ❑ Yes ❑ No Date Diagnosed? __________ Type of Cancer?___________
15. Do you have cardiac problems? ❑ Yes ❑ No Date Diagnosed? _______________
    Specific problems and treatments w/ current status: ____
16. Do you have diabetes? ❑ Yes ❑ No
17. Date of Onset?_______________ Recent A1C level:_____________ Type? ❑ 1 ❑ 2 Insulin Dependent? ❑ Yes ❑ No
18. Have you been diagnosed with a serious condition not listed above? ❑ Yes ❑ No
    If so, please provide some general information about your condition: _____________________________________
19. List immediate family members (parents and siblings) ages, names, sex. If deceased, cause of death and age? ___________
    ____
    ____