

# Pre-Application Questionnaire

**\* Required Fields**

## TELL US ABOUT YOURSELF

### Personal Information

First Name	<input type="text"/>	* Employer / Association	<input type="text"/>	*
Last Name	<input type="text"/>	* Occupation:	<input type="text"/>	
Date of Birth	<input type="text"/>			*
Age	<input type="text"/>		Sex: <input type="radio"/> Male <input type="radio"/> Female	*
Height :	<input type="text"/>		Tobacco Use:	
Weight:	<input type="text"/>		<input type="radio"/> NonSmoker of cigarettes in past 24 moths	
			<input type="radio"/> Smoker of cigarettes in past 24 months	
			<input type="radio"/> Tobacco use in the past 24 months	
Marital Status: *	If Married is spouse currently covered?		With whom do you currently live?	
<input type="radio"/> Married	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Spouse	
<input type="radio"/> Single			<input type="radio"/> Alone	
<input type="radio"/> Partner			<input type="radio"/> Other	

### Contact & Mailing Information

Street	<input type="text"/>	
City	<input type="text"/>	
State	<input type="text"/>	*
Zip code:	<input type="text"/>	
Day Phone	<input type="text"/>	*
Evening Phone	<input type="text"/>	*

A Representative from the Insurance may call you to ask questions about your health. Please indicate the best time to contact you.

Best time to callTime:  a.m.  p.m.

Email Address

\*

IF APPLICABLE TELL US ABOUT YOUR SPOUSE / PARTNER - IF THEY ARE APPLYING

Spouse Personal Information

First name	<input type="text"/>	Employer/ Association	<input type="text"/>
Last Name	<input type="text"/>	Occupation:	<input type="text"/>
Date of Birth	<input type="text"/>		
Age	<input type="text"/>	Sex:	<input type="radio"/> Male <input type="radio"/> Female
Height :	<input type="text"/>	Tobacco Use:	
Weight:	<input type="text"/>	<input type="radio"/> NonSmoker of cigarettes in past 24 moths	
		<input type="radio"/> Smoker of cigarettes in past 24 months	
		<input type="radio"/> Tobacco use in the past 24 months	

Spouse Contact & Mailing Information

Day Phone	<input type="text"/>	<b>A Representative from the Insurance may call you to ask questions about your health. Please indicate the best time to contact you.</b>	
Evening phone	<input type="text"/>	Best time to callTime:	<input type="radio"/> a.m. <input type="radio"/> p.m.
E-mail Address	<input type="text"/>		

MEDICAL HISTORY - PART I

	Primary Insured	Insured Spouse
<b>1. In the past 6 MONTHS - or currently:</b>		
a. Are you receiving disability benefits or worker's compensation?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
b. Due to any present or past mental or physical disability, is any person or insitution authorized to act on your behalf?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
c. Are you dependent on the use of a walker or wheelchair or are you confined to bed or home?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
d. Are you using any medical appliance such as a catheter, oxygen equipment, respirator, or dialysis machine?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

2. In the past 6 MONTHS, have you required assistance or supervision with or are you currently limited in any way from performing any of the following daily activities: eating, bathing dressing toileting, bladder or bowel control, or mobility?

Yes  No

Yes  No

3. Have you ever been diagnosed as having or been treated by a member of the medical profession for any of the following:

a. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Yes  No

Yes  No

b. Diabetes treated with insulin or arthritis treated with chronic steroid use or gold?

Yes  No

Yes  No

c. Alzheimer's Disease, Organic Brain Syndrome, senility, confusion, disorientation, recurring memory loss, or dementia?

Yes  No

Yes  No

d. Parkinson's Disease, Multiple Sclerosis, ALS (Lou Gehrig's Disease), or Muscular Dystrophy?

Yes  No

Yes  No

e. Stroke, congestive heart failure, emphysema/COPD with continued smoking, cirrhosis of the liver, or unoperated aneurysm?

Yes  No

Yes  No

### MEDICAL HISTORY - PART II

If any questions in Part 2 of Medical History are answered YES, please provide details in Comments section below.

**Only mark off those issues that apply.**

1. In the past 10 YEARS have you received medical advice or treatment for the following conditions?

	Primary Insured	Insured Spouse		Primary Insured	Insured Spouse
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Auto-Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Back Disorder/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mental / nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>

Cane Use	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
COPD/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Periphera Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disorders	<input type="checkbox"/>	<input type="checkbox"/>
Chrones Disease or Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Spine/Back disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>
Drug or substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>

**2. In the past 10 YEARS have you been treated by a health professional for any condition not named above?**

Primary Insured	Insured Spouse
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**3. In the past 12 MONTHS have you**

**a. Been confined to a hospital, nursing home, or sanitarium?**

<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
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**b. Received home care services, physical therapy, or rehabilitative therapy?**

<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
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**c. Sought medical advice or treatment for loss of appetite, falling, fainting, problems with balance, sizziness, or deterioration of vision?**

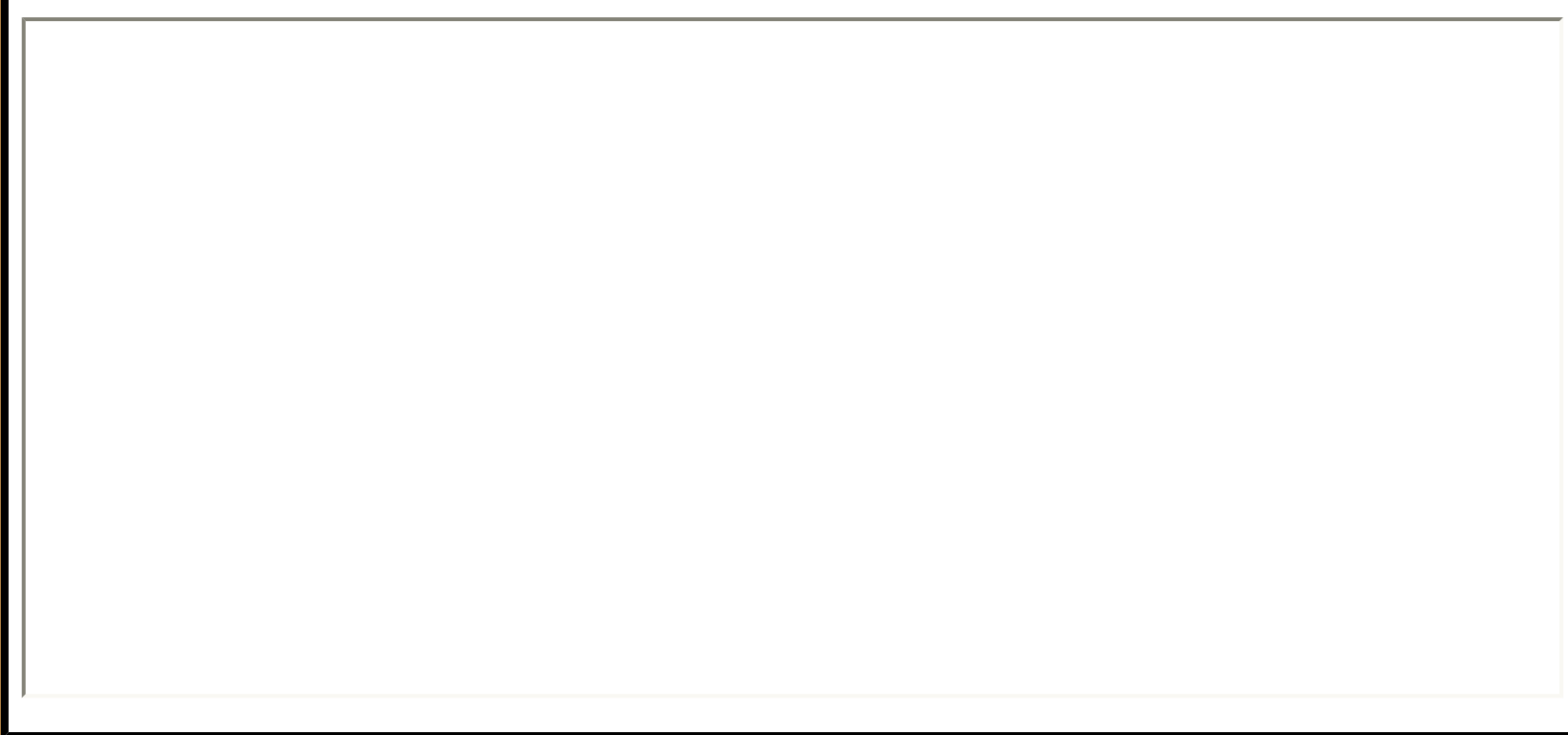
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
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**d. Had any surgical procedure recommended or scheduled?**

<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
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**MEDICAL HISTORY - COMMENTS**

**Provide details to any questions answered "Yes" in Medical History - Parts I & II  
(For both Primary Insured or Insured Spouse)**



**PRIMARY PHYSICIAN INFORMATION**  
**PRIMARY INSURED**

**PRIMARY PHYSICIAN INFORMATION**  
**INSURED SPOUSE / PARTNER**

**Physician Name:**

Phone Number

Mailing Address:

City, State, Zip

**Medical Specialist Name**

Phone Number

Mailing Address:

**Physician Name:**

Phone Number

Mailing Address:

City, State, Zip

**Medical Specialist Name**

Number2

Mailing Address:

City, State, Zip <input type="text"/>	City, State, Zip <input type="text"/>
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CHOOSE YOUR PREMIUM PAYMENT AMOUNT Proposed primary insured	CHOOSE YOUR PREMIUM PAYMENT AMOUNT insured spouse / partner
<b>Frequency</b> (must select one) <input type="radio"/> Annually (this is the least expensive method) <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semiannually	<b>Frequency</b> (must select one) <input type="radio"/> Annually (this is the least expensive method) <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semiannually

DESIGNATION OF THIRD PARTY FOR PROTECTION AGAINST UNINTENDED LAPSE	
<b>Proposed primary insured</b>	<b>insured spouse / partner</b>
<input type="radio"/> I elect <b>NOT</b> to designate any person. <input type="radio"/> I elect to designate this person.	<input type="radio"/> <b>Same as Proposed Primary Insured</b> <input type="radio"/> I elect <b>NOT</b> to designate any person. <input type="radio"/> I elect to designate this person
Full Name: <input type="text"/>	Full Name: <input type="text"/>
Relationship to you: <input type="text"/>	Relationship to you: <input type="text"/>
Address <input type="text"/>	Address <input type="text"/>
Phone <input type="text"/>	Phone <input type="text"/>

Submit