STATEMENT OF HEALTH

INFORMATION CONCERNING DEPENDENTS NOT REQUIRED WHEN APPLYING FOR EMPLOYEE ONLY COVERAGES

	FULL NAME	BIRTH DATE (Mo. Day Yr.)	HEIGHT (Ft - Inch)	WEIGHT	SEX (M-F)
Insured					
Spouse					
Child(ren)					

Have you or any of your above dependents:	**YES**	**NO**
a. ever had any of the following: heart trouble, high blood pressure, lung trouble, kidney trouble, stomach or intestinal trouble, tumors, cancer, diabetes, or any nervous disorders?	❒	❒
b. been a patient in a hospital or similar institutions during the past three years?	❒	❒
c. been examined or treated by, or consulted a physician during the past three years?	❒	❒
d. any known impairments or illnesses?	❒	❒
e. a license of any type to pilot an airplane? (if yes, submit regular company aviation questionnaire)	❒	❒
f. ever been refused insurance or been offered other than a standard policy?	❒	❒

IF ANY QUESTION IN THIS SECTION (except e.) IS ANSWERED "YES", GIVE NAME AND DETAILS BELOW

Name of Individual	Nature of Illness or Injury or Medical Attention	Date and Duration	Any Remaining Effects	Names & Addresses of Physicians or Hospitals

To the best of my knowledge and belief the information is correctly recorded, complete and true in this Part 2, which together with part 1 of the application, form the basis of mu insurance.

This form, or a photographic copy of it, authorizes (to the extent permitted by the state laws of the applicable state) any doctor or other practitioner and any hospital or sanitarium to give the ______________________________ Insurance Company all information you may have concerning my condition, or that of my wife and children to the date of this form, including history, physical and laboratory findings, treatment and prognosis.

Date ______________________________ 19 _______ ______________________________

Signature of Employee