ACCIDENT AND SICKNESS APPLICATION TO :

Applicant's Full Name (print) ❒ Mr. ❒ Mrs. ❒ Miss	Date of Birth	Mail Premium Notices to : ❒ Residence Address ❒ Business Address
Residence Street and Number–City–State–Zip Code	Your Height and Weight ft. in. lbs.	

Occupation	Duties	❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated
Employer	Nature of Business	Address

Names of your family members to be covered:

Full Name (Print)	Relation-ship	Birth Date	Weight	Height	Full Name (Print)	Relation-ship	Birth Date	Weight	Height

1. Have any persons to be covered ever consulted a physician for, or to your knowledge ever had, any of the following: (Circle conditions to which "yes" answer applies and give details in 3 below).

(a) Mental or nervous disorder, disease of the circulatory system, or rheumatic fever? Yes ____ No _____
(b) Tuberculosis, kidney or bladder trouble, prostate trouble or venereal disease? Yes ____ No _____
(c) Disease of lungs or respiratory system, heart, stomach, intestines or gall bladder? Yes ____ No _____
(d) Disease of the muscles or disease of or injury to the spine, back or skeletal system? Yes ____ No _____
(e) Disease or impairment of the eyes or ears, or any physical deformity or abnormality? Yes ____ No _____
(f) Diabetes, cancer, tumor or any form of growth, rheumatism,, arthritis or hernia? Yes ____ No _____

2. During the past five years, have any persons to be covered undergone any special examinations or laboratory tests (x-rays, electrocardiograms, blood or urine tests) or had medical or surgical advice or treatment, or to your knowledge, any departures from good health not mentioned above? (if "yes" give details in 3 below).

3.

PERSON TREATED	CONDITION OR INJURY OR FINDINGS OF EXAMINATIONS	DATE AND DURATION	DEGREE OF RECOVERY	NAME AND FULL ADDRESS OF ATTENDING PHYSICIAN

4. Have any persons to be covered ever received benefits under any accident or sickness policy? (If "yes" state person concerned, company, type of insurance, dates, reasons) __________________ Yes ___ No __

5. Have any persons to be covered ever been postponed, rated-up, ridered, declined or cancelled or has a renewal been refused for life, accident or hospital expense insurance? (If "yes" state person concerned, company, type of insurance, dates, reason) ____ Yes ___ No __

6. Do any persons to be covered carry or have an application pending for any hospital, surgical or medical expense insurance? (If "yes" state person concerned, company name, type of Insurance and benefits) ______ Yes ___ No __

7. To the best of your knowledge and belief are all of the answers to the above questions true and complete? Yes ___ No __

I agree that a copy of this application shall be attached to and form a part of any policy of insurance issued. I understand and agree (a) the proposed insurance shall not take effect unless the application has been accepted and approved by the Company and the first term premium paid in full, (b) the effective date of any Policy issued will be the Effective Date shown in the policy Schedule.

Dated at ______________________________ on the _________________ day of _____________________ 19 _______ .
City, State

Countersignature of
Licensed Resident Agent ________________________________ ____
Signature of Applicant