

COVERAGE QUESTIONS

- 1. Do all members to be insured reside in the home of the applicant? If **NO**, provide details below Yes No
- 2. Has any applicant been declined for insurance due to health reasons? If **YES**, provide details below Yes No
- 3. Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or "AIDS" related conditions, or tested positive for Human Immunodeficiency Virus (HIV) or its antibodies? If **YES**, provide details below. Yes No
- 4. Are you or your spouse now pregnant? If **YES**, provide details below Yes No
- 5. Is the policy intended to replace any other insurance now in force? If **YES**, provide company name, policy number, and type of coverage below. Yes No

Provide additional information requested for questions 1 - 5 in the space provided below:

CANCER/FOB

- 1. Has any person to be covered under the terms of this policy now have or ever had cancer in any form including carcinoma in situ? Yes No
If **YES**, then list the name(s) of the person(s) that will not be issued FOB coverage: _____
- 2. To the best of your knowledge and belief, in the past 10 years has any person to be covered under the terms of this policy had cancer or treated for cancer in any form including carcinoma in situ? Yes No
If **YES**, then list the name(s) of the person(s) to be excluded from coverage _____
- 3. To the best of your knowledge and belief, has any person to be insured ever had a history of melanoma, Hodgkin's disease, or leukemia?. Yes No
If **YES**, then list the name(s) of the person(s) to be excluded from coverage _____
- 4. To the best of your knowledge and belief, within the last 12 months, has any person to be insured had any elevated or rising prostate specific antigen (PSA) or carcinoembryonic antigen (CEA) tests; abnormal mammogram, pap smear radiological exam, biopsy or scope procedure; or, received treatment, including those during course of routine checkups, where the results were other than normal or still pending?. Yes No
If **YES**, then list the name(s) of the person(s) to be excluded from coverage _____
- 5. I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated for Addison's disease, amyotrophic lateral sclerosis, diphtheria, encephalitis, epilepsy, legionnaires' disease, lupus erythematosus, meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann Pick disease, osteomyelitis, poliomyelitis, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, sickle cell anemia, Tay-Sachs disease, tetanus, toxic epidermal necrolysis, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Whipple's disease, and whooping cough?. Yes No
If **YES**, please circle the disease(s) and list the name(s) of the person(s) to be excluded from dread disease coverage _____
- 6. **Critical Care/Intensive Care Rider:** Has any person to be insured ever received medical care for or been diagnosed with heart disease, heart surgery, any abnormalities of the heart, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery, or been diagnosed or treated with high blood pressure unless controlled by diet and/or medication for at least one year?. Yes No
If **YES**, then list the name(s) of the person(s) to be excluded from coverage _____