

## PART 3 INSURABILITY QUESTIONS

**SIMPLIFIED UNDERWRITING PROGRAM** – If you are part of the Simplified Underwriting Program please complete Section A and skip to Part 4. If you are part of the full underwriting program please complete all Parts of the application.

### Section A

- ♦ Please check “yes” or “no” to each question. If “yes”, circle all diagnoses or conditions that apply.
- ♦ If you answer “yes” to any question 1-6, then we suggest you do not submit an application. We will be unable to offer you coverage.

	Applicant A	Applicant B
<b>1</b> Do you have or have you ever been diagnosed for:		
<ul style="list-style-type: none"> <li>♦ Alzheimer’s Disease</li> <li>♦ ALS (Lou Gehrig’s Disease)</li> <li>♦ Cirrhosis</li> <li>♦ Chronic Kidney Failure</li> <li>♦ Dementia</li> <li>♦ Diabetes –treated with greater than 49 units of insulin or with amputation or ongoing complications affecting the kidney</li> <li>♦ Memory Loss</li> <li>♦ Mental Retardation</li> <li>♦ Metastatic Cancer</li> <li>♦ Multiple Sclerosis</li> <li>♦ Muscular Dystrophy</li> <li>♦ Neurological Conditions affecting the Brain or Spinal Cord</li> <li>♦ Organic Brain Syndrome</li> <li>♦ Parkinson’s Disease</li> <li>♦ Paralysis</li> <li>♦ Post Polio Paralytic Syndrome</li> <li>♦ Schizophrenia</li> <li>♦ Scleroderma</li> <li>♦ Systemic Lupus Erythematosus</li> <li>♦ Stroke/CVA</li> <li>♦ TIA’s 2 or more</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2</b> Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3</b> Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4</b> Do you currently use one of the following medical devices: wheelchair; walker; hospital bed; quad cane; oxygen; stairlift; or dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b> Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6</b> Are you currently receiving Social Security Disability, Worker’s Compensation or Long Term Disability Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SAMPLE

### Section B

If you are part of the Simplified Underwriting Program please skip to Part 4.

MEDICAL HISTORY	Applicant A	Applicant B
<b>1</b> Have you consulted with your Primary Care Physician within the last 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Applicant A:</b> Primary Care Physician Name: _____ Address: _____ City, State, Zip Code: _____ Tel. #: _____ Date Last Seen: _____	<b>Applicant B:</b> Primary Care Physician Name: _____ Address: _____ City, State, Zip Code: _____ Tel. #: _____ Date Last Seen: _____	