

**PART B**

**INSURABILITY QUESTIONS**

**SIMPLIFIED UNDERWRITING – Answer questions in Parts B and C, skip Part D (not applicable to Simplified Underwriting) and continue to Part E.**  
**MODIFIED UNDERWRITING – Answer questions in all sections.**

	APPLICANT 1	APPLICANT 2
<p>1. Have you been medically advised as having or have you been medically treated for: <b>Circle all that apply</b></p> <ul style="list-style-type: none"> <li>• Stroke (CVA)</li> <li>• Multiple Transient Ischemic Attacks (TIA's)</li> <li>• TIA within 5 years</li> <li>• Alzheimer's Disease</li> <li>• Dementia</li> <li>• Mental Retardation</li> <li>• Schizophrenia</li> <li>• Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)</li> <li>• Muscular Dystrophy</li> <li>• Multiple Sclerosis</li> <li>• Parkinson's Disease</li> <li>• Diabetes with amputation or complications affecting the kidney</li> <li>• Cancer that has spread to another area of your body including nodes; or cancer diagnosed or treated in the past 2 years (except basal cell cancer, squamous cell cancer of the skin or early stage breast or prostate cancer).</li> <li>• Organ Transplant</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Have you ever been treated for or medically diagnosed as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), any AIDS related condition(s) or tested positive for antibodies to the AIDS virus?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Do you currently reside in, or have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or residential care facility or are you currently receiving home health care services or attending Adult Day Care?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Do you require human help or supervision for any of the following?:</p> <ul style="list-style-type: none"> <li>• bathing • dressing • eating • walking • toileting</li> <li>• transferring from bed or chair • controlling bowel or bladder</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Do you currently use any of the following?:</p> <ul style="list-style-type: none"> <li>• dialysis • oxygen • wheelchair • walker • quad cane • crutches</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY**

**Complete this section if:** You are part of a Simplified Underwriting group, and your Spouse's or Domestic Partner's employer is paying the premium.

Do you currently need or receive help with any of the following activities because you are unable to perform them yourself?

Yes  No

- taking medications • shopping • meal preparation • managing finances

**IF "YES"** please explain:

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This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.

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