

MEDICAL INFORMATION

Prosposed Insured:	•
Please answer all of the questions indicated wit	
1. Treated for (please indicate exact medic	cal term):
2. What was the cause?	
3. Date first treated:	
4. Treatment prescribed and/or surgery per	formed? (Y/N) If YES, please give details.
5. Hospitalized? (Y/N) If YES, length or	f stay:
6. Are you still being treated? (Y/N) If Y doctor visits. If NO, indicate the date released	YES, please give details on the frequency and type of your from doctor.
7. Names, strengths, dosages of all medica	tions prescribed:
Still taking medication? (Y/N) If No	, date stopped:
8. Blood pressure reading:	Date:
9. Broken Bones: Are either pins or screw (Y/N) Permanent Temporary l Inpatient Outpatient	•
10. Date of complete recovery:	
11. Are you still disabled? (Y/N) if YES	S, please describe.
12. Complications or remaining problems?	(Y/N) If YES, please describe.
13. Please advise if any pending treatment	or surgery is recommended.
14. Please advise of any malignancy.	
15. Do you smoke? If yes, how many ciga	rettes per day?
16. Other details:	
I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued and that any incorrect answers may operate to void this insurance.	
Date: Signature of Prop	oosed Insured:

Use reverse side for additional comments or if further space is required.