ENROLLMENT QUESTIONNAIRE

1. General Information

Name: _____

Street Address: _____ City, State, Zip: _____

Phone: _____ Alternative: _____ Email: _____

Current Insurance Provider/ Premium: _____ Annual Household Income: _____

Primary D.L. No.:_____ Spouse D.L. No.: _____

2. Household Information

Please complete the information below for everyone in your household

Legal Name	Birthdate	Gender	Social Security #	Height	Weight	US Citizen Yes/No	Birth Place State /Country	Smoker Yes/No

Primary Employment Info: _____

Employer Address: _____City, State, Zip: _____

Employer Phone: _____ Primary Income: _____

Spouse Employment Info: _____

Employer Address: _____City, State, Zip: _____

Employer Phone: _____ Monthly Income: _____

3. Beneficiaries

Primary Name (First, Last, Middle)	Date of Birth	Social Security #	Relationship	Share %
1.				
2.				

Contingent Name (First, Last, Middle)	Date of Birth	Social Security #	Relationship	Share %
1.				
2.				

Initials: _____ Initials: _____

4. General Health Questions

1. If under the age of 65, is any Proposed Insured receiving Medicare or Medicaid? **YES** **NO**

   If ***YES***, name of person(s): _____

2. During the past **5 years**, has any Proposed Insured had a critical illness insurance application postponed, rated up or declined? **YES** **NO**

   If ***YES***, please explain: _____

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? **YES** **NO**

   If ***YES***, please explain: _____

4. Is any Proposed Insured currently negotiating for other insurance coverage? **YES** **NO**

   If ***YES***, please explain: _____

5. Is there other critical illness insurance coverage in force for any Proposed Insured? **YES** **NO**
   If ***YES***, please provide details below.

   If this insurance is issued, will it replace, modify, or borrow against existing or pending accident or sickness coverage? **YES** **NO**

Insured Name	Company Name	Policy No.	Type of Coverage	Benefit Amount

5. Medical History

Has anyone applying for coverage been diagnosed and/or treated for any of the following? If answering yes to any condition, please circle the number and provide detail in the space provided below. Also, please list all surgeries within the previous five years.

1. Acquired Immune Deficiency Syndrome (AIDS)
2. AIDS Related Complex (ARC)
3. Alcohol or Drug Abuse
4. Alzheimer's Disease
5. Arterial Disease
6. Bipolar Disorder/ Manic Depression
7. Bone Disease
8. Cancer (Other than skin cancer)
9. Cerebrovascular Accident (CVA)
10. Chronic Obstructive Lung Disease (COLD)
11. Chronic Obstructive Pulmonary Disease (COPD)
12. Cirrhosis
13. Crohn's Disease
14. Diabetes
15. Emphysema
16. Fibromyalgia
17. Grand Mal Epilepsy
18. Heart Attack
19. Heart Disease
20. Heart Surgery
21. Hepatitis B or C
22. Human Immunodeficiency Virus (HIV)
23. Insulin Dependent Diabetes
24. Internal Cancer
25. Kidney Disease
26. Liver Disease
27. Lou Gehrig's Disease (ALS)
28. Lupus Erythematosus
29. Major Depression
30. Melanoma Cancer
31. Multiple Sclerosis
32. Muscular Dystrophy
33. Myositis/ Fibromyositis
34. Organ Failure
35. Organ Transplant
36. Organic Brain Syndrome/ Dementia
37. Osteoporosis with History of Bone Fracture
38. Paralysis (any type of degree)
39. Peripheral Vascular Disease
40. Rheumatoid, Psoriatic, or Disabling Arthritis
41. Severe Degenerative Joint Disease
42. Stroke
43. Substance Abuse
44. Transient Ischemic Attack (TIA)
45. Ulcerative Colitis
46. Recurrent human papillomavirus (HPV) or sexually transmitted disease (within past 5 years)
47. Systolic blood pressure 150 or greater
48. Diastolic blood pressure 95 or greater (both within the past six months)
49. Currently taking medications

Initials: _____ Initials: _____

Condition No. & Family Member	Date Diagnosed	Treatment	Date Treatment Concluded

1. During the past **2 years**, has any Proposed Insured been advised by a member of the medical profession:

   a. Of any abnormal diagnostic test results or been advised to have any diagnostic tests (including self-administered) which has not been completed, or for which the results have not need received? **YES** **NO**

   b. To undergo any treatment, surgery, hospitalization or consultation with a medical professional which has not been completed? **YES** **NO**

   c. To refer to a specialist and have not done so? **YES** **NO**

   If ***YES***, what specialty: _____

2. Have **2 or more** of any Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the same conditions from the following list?

   a. Heart Disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? **YES** **NO**

   b. Colorectal cancer or Alzheimer's disease or senile dementia prior to age 75? **YES** **NO**

   c. Any other same type of cancer in both relatives prior to age 55? **YES** **NO**

   If ***YES***, please list conditions and relationships to the Proposed Insured(s): _____

   _____

6. Premium Payment Information

If Paying by EFT

Bank Name: _____

Routing Number: _____

Account Number: _____

Account Holder: _____

If Paying by Credit Card

Credit Card: Visa _____ MasterCard _____

Card Number: _____-_____-_____-_____

Exp. Date: _____/_____ 3 Digit Code: _____

Cardholder: _____

I (we) have read the above answers and declare that they are complete and true to the best of my (our) knowledge and belief. Further, I (we) grant my (our) consent to have my (our) application(s) for coverage submitted online on my (our) behalf based solely upon the information I (we) provided.

Applicant Signature: _____ Spouse Signature: _____