



**North American Company**  
 for Life and Health Insurance  
 Principal Office: 4601 Westown Pkwy, Suite 300  
 West Des Moines, IA 50266

A Member of the Sammons Financial Group



L2875251

## STATEMENT OF HEALTH

Name of Proposed Insured: \_\_\_\_\_ Policy Number(s): \_\_\_\_\_

Please complete this Statement of Health as a condition to the Delivery or change of the policy(ies) referenced above. **If the answer to any question is checked "yes", please explain in the "Details" section below.** Pertinent dates, severity, treatment, duration, outcome; names, addresses of physicians, hospitals or clinics should also be included, along with any "Exceptions" to any of the statements below.

<b>This is to certify, that since the date of the original application(s) I (the Insured):</b>	<b>YES</b>	<b>NO</b>
1. have consulted or been treated by any physician or practitioner or had any physical disability or impairment, sickness, injury, surgery or mental disorder;	<input type="checkbox"/>	<input type="checkbox"/>
2. have had a physical examination, lab tests, EKG or X-ray procedures;	<input type="checkbox"/>	<input type="checkbox"/>
3. have used tobacco in any form; (If Yes, give form used, number per day and length of time used in "Details".)	<input type="checkbox"/>	<input type="checkbox"/>
4. have made an application(s) for insurance which has been declined, postponed, or modified;	<input type="checkbox"/>	<input type="checkbox"/>
5. have other application(s) for insurance pending with another company(ies) at the present time	<input type="checkbox"/>	<input type="checkbox"/>
6. have changed occupation (if yes, give all occupations-employers; types of industry and duties.)	<input type="checkbox"/>	<input type="checkbox"/>
7. have engaged in or expect to engage in any of the following: aviation activities as a pilot or crew member; aqualung or skin diving; automobile, motorcycle or motor boat racing; mountain climbing; rodeo competition; sky-diving or other hazardous activities	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS:

I certify that I have read the above completed health statement or that it has been read to me. I understand that any false statement or representation in the application and/or health statement may result in loss of coverage under the policy/certificate. I agree that the answers given above will become a part of the original application, including any supplement to the application. So far as I know and believe, the original application, as changed above, is true, complete and up-to-date

\_\_\_\_\_  
 Signature of Proposed Insured

\_\_\_\_\_  
 Signature of Proposed Owner\*

\_\_\_\_\_  
 Date

\*If signing on behalf of a corporation, trust, or other entity, print your title next to your signature.