



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. AIDS test results obtained at an anonymous counseling and testing site are confidential and need not be disclosed. None of these questions should be interpreted as asking about AIDS unless the question specifically mentions AIDS or AIDS testing.

This is to certify, that since the date of the original application(s) I (the Insured):	YES	NO
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.