



APPLICATION FOR GROUP INSURANCE & STATEMENT OF HEALTH

Corporate Solutions

Application for: <input type="checkbox"/> Employee/Member <input type="checkbox"/> Dependent	Last Name	First Name	Middle Name	Date of Birth Month Day Year		
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Name of Employer or Association	Group Policy No.
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Group Insurance Involved P	In-Force P	Applied For P	Height	Weight
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Please check <input checked="" type="checkbox"/> reason for submitting Health Statement	<input type="checkbox"/> LATE ENROLLMENT	<input type="checkbox"/> OVER AGE LIMIT	<input type="checkbox"/> REINSTATEMENT	<input type="checkbox"/> AMOUNT OVER SCHEDULED LIMIT
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Please answer the following questions by checking the "Yes" or "No" box.			Use this space or the reverse hereof to give full details of question 1 or 2 answered "No" or 3-6 answered "Yes". All statement contained on the reversed are hereby made part of this form. (If answers to question 5a to 5d and 6 give full date, symptoms, duration, treatment, results, name of M.D., hospital and address).
	YES	NO	
1. Are you now actively at work on a regular, full-time basis?			
2. Are you in good health?			
3. Has any application on your life for Life, Accident or Hospitalization insurance been declined, postponed or modified?			
4. Have you had any deformity, impairment of sight, hearing or loss of any part of the body or other physical defects?			
5. Have you during the past 5 years:			
a. Any injury, ailment or disease?			
b. Consulted or been treated by any physician or medical practitioner?			
c. Had any surgical operation?			
d. Had any medical examination or check-up?			
6. Have you ever been confined in any hospital, clinic or similar institution?			

I hereby declare and agree that all statement and answers contained herein are full, complete and true. In the event, I undergo & medical examination, my statement, and representations thereunder shall take place of the above questionnaire for purpose of this application. I understand that the insurance applied for will not become effective until the application is approved by the Insurance Company at its Home Office. If this application is for additional insurance, I agree that the beneficiary of my insurance under said policy or policies shall be the beneficiary of said additional amount of insurance.

IN CASE OF A MINOR DEPENDENT, I SIGN THIS CERTIFICATE IN MY BEHALF AS PARENT AND IN BEHALF OF THE MINOR DEPENDENT

Date	Signature of Dependent /Spouse	Signature of Employee/Member
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HOME OFFICE UNDERWRITING ANALYSIS

INDEX SEARCH
