

# American General

Life Companies

## Tampa New Case Submission Checklist

### American General Life Insurance Company of Delaware\*

Wilmington, Delaware

### United States Life Insurance Company in the City of New York

New York, New York

Administrative Office: P.O. Box 30081, Tampa, FL 33630-3081

Street Address: 3501 Frontage Road, Tampa, FL 33607

Phone: 877-672-1648 Fax: 877-672-1651

\*This company does not solicit business in New York.

**In order to install the below named group we must receive the required paperwork. The applicable requirements are listed below.**

Group Name: \_\_\_\_\_ Group Effective Date: \_\_\_\_\_

American General Sales Representative: \_\_\_\_\_ Code: \_\_\_\_\_

Master General Agent: \_\_\_\_\_ # \_\_\_\_\_ Producer: \_\_\_\_\_ # \_\_\_\_\_

Submitted By: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Date: \_\_\_\_\_

#### For all Employer-funded and/or Employee-Paid products the below data must be submitted.

- Master Application<sup>1</sup> – not applicable for Individual products.
- Sold Quote – benefits and number of employees should match application and enrollment forms/census list.
- Large Group Underwriting Exhibits and Assumptions, if applicable.
- If replacing coverage, provide Current Prior Carrier Bill and Certificate/Booklet

#### For Employer-funded and/or Employee-Paid products (excluding Worksite products<sup>2</sup>) the below data must be submitted 10 business days prior to the requested effective date.

- Is group applying for any other American General benefit coverage? If yes, type of coverage? \_\_\_\_\_
- Census
- Employee Enrollment Form
- Deposit check – should match quote or one month's premium
- Excess Insurance Application<sup>1</sup> – if applicable
- Waiver forms
- Statement of Insurability for Group Programs<sup>1</sup>
- Payroll Deduction Authorization form – to be submitted separately following completion of case set-up – if applicable
- Quarterly Wage & Tax – required for employees age 70 and above, high family content or questionable eligibility

#### For all Employer-funded and/or Employee-paid STD or LTD products the below data must be completed.

W2 Election (applicable for STD & LTD only)

If you need American General to provide W2's for your employee's, please complete form # 06233413-1005 available on our forms website referenced below and return it promptly to the address noted on the form. You will be receiving your administration kit shortly after the issuance of your policy.

#### For Worksite products<sup>2</sup> the below data must be submitted.

**Pre-Enrollment** – requirements must be submitted a minimum of 10 business days prior to the first scheduled date of enrollment.

- Employers Agreement
- Case Data Sheet
- Census – Employer-funded only

**Post-Enrollment** – requirements must be submitted 10 business days prior to the requested effective date.

- Individual Application for Insurance<sup>1</sup>
- Payroll Deduction Authorization
- HIPPA authorization – applicable for all Individual products except Life and DI<sup>2</sup>
- Replacement forms – Individual products, if applicable

#### Please indicate the billing method:

Home Office  Self Billing (over 100 lives)

Is a Chartis A&H policy being submitted in addition to this application?  Yes  No

Special Handling requests: \_\_\_\_\_

Send Administration Kit to:  Policyholder  General Agent  Producer/Broker  Account Manager  Sales Rep  
**Unless otherwise noted above, the Administration Kit will be sent directly to the Policyholder for groups less than 200 lives and to the Account Manager for Groups of 200 or more lives.**

1. The Master Application, Statement of Insurability forms and Group Worksite Employee Enrollment applications may be subject to state laws. For the complete listing of available forms please visit our online ordering system at <http://forms.agebs.com>.

2. Universal Life, Level Term Life, Return of Premium Term Life, Critical Illness, Cancer, Accident, Hospital Indemnity and Disability Income

**Send new case submissions to TSC Case Implementation Department at the address listed above or email to:  
newbusiness@agebs.com**

# American General

Life Companies

# MASTER APPLICATION FOR EMPLOYEE BENEFITS

American General Life Insurance Company of Delaware\*

Wilmington, Delaware

Administrative Office: P.O. Box 30083, Tampa, FL 33630-3083

\* This company does not solicit business in New York

## Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

**(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)**

## Applicant Data

1. Full Name of Applicant (Company): \_\_\_\_\_

2. Group Contact Name: \_\_\_\_\_

3. Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ SIC Code: \_\_\_\_\_

4. Applicant is a:  Proprietorship  Partnership  Corporation  Union

Other (Explain): \_\_\_\_\_

5. Nature of Business: \_\_\_\_\_ & Number of years in business \_\_\_\_\_

6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered?  Yes  No

If yes, give details below. If more space is needed, attach a separate sheet.

<i>Name of Company</i>	<i>Nature of Business</i>	<i>Full Address</i>	<i># of Full-Time Employees</i>
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you ever applied for, or been insured for, group insurance with any affiliated American General Companies, including United States Life?  Yes  No

If yes, give details: Group Policy Number(s) \_\_\_\_\_

Date Insurance Ended/Declined \_\_\_\_\_ Effective Date (if still insured) \_\_\_\_\_

8. Please complete the information below for those coverages being replaced:

<i>Current Coverage</i>		<i>Replacing with the Company's Plans?*</i>		<i>Prior Plan Name &amp; Effective Date</i>	<i>Proposed Termination Date</i>
<i>Employer</i>	<i>Employee Pay All</i>	<i>Yes</i>	<i>No</i>		
Life**	<input type="checkbox"/> Life**	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
ADD	<input type="checkbox"/> ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Vision	<input type="checkbox"/> Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
STD	<input type="checkbox"/> STD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
LTD	<input type="checkbox"/> LTD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Critical Illness	<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Hospital Indemnity	<input type="checkbox"/> Hospital Indemnity	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Accident	<input type="checkbox"/> Accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

\* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

\*\* Are there other Employer Sponsored plans in force which you are not replacing or currently applying for with another carrier?

Yes  No

If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

## Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least \*30 hours (20 hours for Employee Pay All Life only) per week, or \_\_\_\_ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage?  Yes  No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** \_\_\_\_\_

\_\_\_\_\_ Total # of excluded employees \_\_\_\_\_

\* Amount of hours may vary by state law.

## Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees  \_\_\_\_\_ months OR  First of the month following \_\_\_\_\_ months\*  
 Future Employees  \_\_\_\_\_ months OR  First of the month following \_\_\_\_\_ months\*

\*Only option available for Employee Pay All Coverages. Available on Group coverages with the 1<sup>st</sup> of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued)..... \_\_\_\_\_

b. Number of Full-Time Employees **waiving all coverages** ..... \_\_\_\_\_

12. Do you employ 20 or more employees? (Include part-time, union, etc.)  Yes  No

## Contribution Data – Not applicable to Employee Pay All Coverages

13. Will the employees be required to contribute toward the cost of the insurance?  Yes  No

If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

*NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.*

Coverage	Life	AD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD	Critical Illness	Cancer	Hospital Indemnity	Accident
Employer %													

\* The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid:  Annually  Semi-annually  Quarterly  Monthly  EFT

## Employee/Dependent Data

15. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days?  Yes  No

If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE:**

**This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	Date Disability Began	Current Amount of Group Life Insurance in Force	Describe Nature of Injury/Sickness	Date Return to Full-Time Work

## Requested Effective Date

I request that the coverage(s) chosen take effect on:

the date the application is approved in writing by the Company; or

\_\_\_\_\_ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included.

For Employee Pay All Plans, the effective date must be the first of the month.

## Applicant's Declaration

1. I verify that all employees applying for coverage listed on the census form are actively at work and working at least \*30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): \_\_\_\_\_.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
6. I understand and agree that:
  - no agent may change or waive any of the provisions of this application or of any plan of insurance;
  - any change or waiver may be made only by an officer of the Company; and
  - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
  - If the insurance contract compromises a part of an employee benefit plan, the Company is granted \*\* sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

DATE

PRINT NAME & TITLE OF OFFICER, PARTNER, PROPRIETOR

WITNESS

SIGNATURE OF OFFICER, PARTNER, PROPRIETOR

\* Amount of hours may vary by state law

\*\* May not be applicable in all states, and may vary by state law

The Policyholder Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

## Producing Agent's Declaration

Please Print			PRODUCING AGENT		
Producer #	Tax ID # / SS#				% Commissions split with other agents
Name as <b>Licensed</b>			License #		
Mailing Address					
City / State / Zip					
Phone		Fax		E-Mail	
<i>Signature</i>		<i>Date</i>		<i>City and State Where Signed</i>	

Please Print			GENERAL AGENT		
General Agent #	Name				Tax ID # / SS#
Phone	Fax				E-Mail

### HOME OFFICE USE ONLY

Policy No.	Premium Deposit \$	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

### **Disclosure Regarding Compensation**

Your insurance or benefits advisor can offer you advice and guidance as you select the policy and provider most appropriate for your needs. At American General Life Insurance Company of Delaware we recognize the important role these professionals play in the sale of our products and services and offer them a variety of compensation programs. Your advisor can provide you with information about these programs. We support disclosure of broker compensation so that customers can make an informed buying decision.

Brokers may be eligible to receive Base Commissions and Supplemental Compensation from American General Life Insurance Company of Delaware.

Unless you have agreed in writing to compensate the broker differently, American General Life Insurance Company of Delaware provides Base Commissions to all producers in connection with the sale of an insurance policy. Base Commissions are a fixed percentage of the policy premium, and include a one time, first year flat amount for each policy sold. Base Commissions are paid by American General Life Insurance Company of Delaware to your producer as long as they remain the broker of record on your policy.

A producer may also qualify for Supplemental Compensation paid by American General Life Insurance Company of Delaware. For group insurance products, Supplemental Compensation may be paid in an amount equal to a fixed percentage of total group insurance premiums. The Supplemental Compensation percentage may range from 0% to 7% of total premiums paid. The exact Supplemental Compensation percentage payable to any producer is based upon the total dollar amount of all group insurance premiums or number of policies that the broker had in force with American General Life Insurance Company of Delaware and affiliated American General Companies in the prior calendar year. Supplemental Compensation may be calculated differently for other insurance products. The premium you pay is not impacted whether or not your broker receives Supplemental Compensation.

If you would like additional information about the range of compensation programs our company offers for your group insurance policy or any other American General Benefits Solutions product, you can find more details at [\[www.AmericanGeneral.com/employeebenefits\]](http://www.AmericanGeneral.com/employeebenefits). Should you have other questions not addressed by the website, including Supplemental Compensation, please contact your Benefits Solutions representative.

**CENSUS INFORMATION** (This form may be photocopied if additional supply is needed) – Not applicable for Employee Pay All Coverages

For H.O. Use Only Class/Div.	Employee's Soc. Security #	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth M D Y	Date of Hire	Marital Status**	# of dependents	Coverage Election E- Employee S-Spouse, C-Child	Coverage Selected – Please check										
											Life	LTD	STD	INT. DIS	Dental	Vision	Critical Ill.	Cancer	HIP	Accident	
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
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16.																					
17.																					
18.																					
19.																					
20.																					

\*Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.

\*\*Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced

\*\*\*Please state if salary is per hour, per week, per month or per year.

For H.O. only: Group Number: _____
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Wilmington, Delaware

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Phone: 1-877-672-1648, Fax: 1-877-672-1650

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Completing Your <b>GROUP ENROLLMENT FORM</b> 1. <b>Fully complete</b> each section 2. <b>Sign and date</b> Refusal/Authorization Section, as needed.		Group Policy No.(s)	<input type="checkbox"/> <b>NEW ENROLLMENT</b> <input type="checkbox"/> <b>CHANGE IN ENROLLMENT</b>
<b>1. PERSONAL DATA: (Must always be completed)</b>			
Billing Location	Class	Social Security No.	Last Name
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM DD YY	Street Address	City
Name of Employer		Location	Salary \$ Per
Occupation	Title	Date of Full-Time Employment MM DD YY	No. Hours Worked <input type="checkbox"/> Union <input type="checkbox"/> NonUnion
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Dependent Children No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, #		
<b>2. ENROLLMENT</b>			
If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.			If high/low dental, please select one.  <input type="checkbox"/> High <input type="checkbox"/> Low
Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.			
Name	Relationship Self Sp. Ch.	Date of Birth MM/DD/YY	Sex
SELF	X		
<b>3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate</b>			
Life Amount for: Employee \$	Spouse \$	Dependent \$	
<b>4. Supplemental AD&amp;D Benefit: If this benefit is a plan option and you wish to enroll for Supplemental AD&amp;D coverage, please indicate</b>			
AD&D Amount for: Employee \$			
<b>5. Beneficiary Designation: as is</b>			
EX: MARY A. JONES, WIFE	First Name	Initial	Last Name
NOT MRS. JOHN JONES			Relationship
<b>6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)</b>			
I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by AG Life Insurance Co. of DE.			
<b>I am refusing:</b> <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> All coverages offered			
<b>Dental:</b> <input type="checkbox"/> Employee & Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> All Dependents			
<b>Vision:</b> <input type="checkbox"/> Employee & Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> All Dependents			
<b>MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:</b>			
Are you or your dependents now covered by any other group plan? <input type="checkbox"/> YES <input type="checkbox"/> NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)			
If Yes: Policyholder's Name _____ Carrier _____			
I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.			
If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.			
I must furnish, at my expense, <b>evidence of insurability</b> satisfactory to AG Life Insurance Co. of DE if I later wish to enroll in any other coverage that is now being refused.			
DATE OF REFUSAL		SIGNATURE IF REFUSING ANY COVERAGE	
<b>*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.</b>			
<b>7. AUTHORIZATION:</b>			
• I hereby certify that all information furnished is true to the best of my knowledge. • I request group insurance for which I am or may become eligible. • If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to AG Life Insurance Co. of DE		• I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death. • If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by AG Life Insurance Co. of DE. • I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to AG Life Insurance Co. of DE information about me. Such information will pertain to my employment or other insurance coverage.	
DATE SIGNED		APPLICANT'S SIGNATURE	

## American General Life Insurance Company of Delaware\*

Wilmington, Delaware  
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### **These Notices must be detached and retained by the applicant**

#### **MIB DISCLOSURE NOTICE**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

#### **NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)**

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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Please print or type all information requested. **Group Policy Number** \_\_\_\_\_ **Billing Location** \_\_\_\_\_

**All applications missing information will be returned.** **Salary** \_\_\_\_\_ **Supplemental Life amount** \_\_\_\_\_  
(if applicable)

**Job Title** \_\_\_\_\_ **Hire Date** \_\_\_\_\_

1. Name of Employer \_\_\_\_\_

2. Employee's/Member's full name \_\_\_\_\_  
FIRST MIDDLE LAST

3. Home Address \_\_\_\_\_  
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Complete the following for employee/member and dependents requesting coverage (Only complete for children if late entrants).

	Name	Age	Date of Birth MM/DD/YY	Sex	Place of Birth	Height	Weight	Social Security #
EE						ft. in.	lbs.	
SP						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

- EMPLOYEE/  
MEMBER**      **SPOUSE**      **CHILD**
5. Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver or lungs, cancer or other tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder?       Yes  No       Yes  No       Yes  No
- 6a. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?       Yes  No       Yes  No       Yes  No
- 6b. Are you presently taking any medication?       Yes  No       Yes  No       Yes  No
- 6c. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?       Yes  No

**If "yes" to any part of questions 5 and 6, give details below. Use a separate sheet of paper if more space is needed for answers:**

Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Name, Address & Phone # of Physicians Hospitals/Clinics Consulted

**SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE**

