



**ASSURANT**  
Health

## **Employer Sponsored Business Questionnaire**

The purpose of this statement is to obtain the information necessary to determine eligibility for medical coverage offered to individuals and families. We appreciate your cooperation.

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I am knowingly applying for individual health insurance coverage. I understand that this is not small group coverage. I further understand and agree that this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. I certify that my employer is not contributing in any way toward the payment of my premium.

My signature indicates that I have read and understand this statement and that the statement is true to the best of my knowledge and belief.

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Signature of Proposed Insured

Date

**Time**  
Insurance