Health Application Questionnaire

Name_______________________________Date of Birth ________________

Height _______________ Weight________________Tobacco Use_______________

Spouse _____________________________Date of Birth _________________

Height _______________ Weight________________Tobacco Use_______________

Child _______________________Date of Birth____________Sex _____Ht.____Wt___
Child _______________________Date of Birth____________Sex _____Ht.____Wt___
Child _______________________Date of Birth____________Sex _____Ht.____Wt___
Does any child use Tobacco Products?____________________

County ____________________________ Home Phone________________________

Address_____________________________ Work Phone ________________________

City _______________________________ State ____________Zip_______________

Your Occupation_______________________________ Spouse's__________________

(1)
Within the last 10 years: Have you or anyone you want us to insure had Cancer, Diabetes, HIV, Aids, Allergies, Asthma, Arthritis, Seizures, Stroke, Heart trouble, Back problems, High blood pressure, Alcohol abuse, Mental (including depression) or Drug abuse problems, or any other chronic disease? _________ If yes please explain.

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(2)
Have you or anyone been in the hospital or had symptoms, pursuing medical treatment in the last 10 years________ If yes, please explain.

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(3)
Please list all Prescription Drugs you or anyone you want us to insure are presently taking or have taken in the last 10 years.

______________________ ___________________________ ______________________
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(4)
Are you or anyone else you want us to insure, pregnant?______ If so when is the baby due?____