

Underwriting Form

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 Nashville, TN 37214
 Phone [(800) 787-2680/Fax (615) 872-1077]



651 Perimeter Drive, Suite 300
 Lexington, KY 40517
 Phone [(800) 787-2680/Fax (859) 335-3750]

Employer		Occupation/Job Title			Social Security Number		
Last Name		First Name, MI		DOB (MM/DD/YY)	Height	Weight	Gender (circle one) Male Female
City	State	Date of Full-Time Hire	Part Time (circle one) YES NO Hours Per Week _____	COBRA (circle one) YES NO Expiration Date _____		Retired (circle one) YES NO	

Type of Contract: Employee Employee/Spouse Employee/Child(ren) Family

Dependents to be covered – List your spouse and/or eligible dependents to be covered. Use separate form for additional dependents.

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Height	Weight	Gender (M/F)
Spouse				
Child 1				
Child 2				
Child 3				

Individual Health Information (2 – 50)

Please answer all of the following questions for yourself and any covered dependents.

Explain any YES responses in the box provided below.

- | | | |
|--|------------------------------|-----------------------------|
| | YES | NO |
| 1. Do you or any of your dependents regularly take medication? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 2. Are you or any of your dependents currently pregnant? If so, when is the expected date of delivery? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 3. In the last five (5) years have you or any of your dependents ever had or received treatment or been advised of having: | | |
| a. Any heart or circulatory disorder including, but not limited to high blood pressure, anemia, chest pain, angina or aneurysm? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| b. Any lung or respiratory disorder including, but not limited to asthma, emphysema, COPD or bronchitis? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| c. Any type of tumor or cancer including, but not limited to melanoma, leukemia or lymphoma? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| d. Any type of mental or nervous condition or alcohol or drug abuse, including professional counseling? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| e. Back, joint, bone or muscle disease or disorder including arthritis (rheumatoid or osteo), lupus, multiple sclerosis (MS) or rheumatism? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| f. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), any disease or disorder of the immune system or tested positive for AIDS virus? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| g. Any nervous system disorder including, but not limited to migraines, stroke, seizures, tremors, Parkinson's or Alzheimer's? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| h. Colitis, Crohn's disease, diverticulitis, other colon problems, ulcers or stomach trouble or any type of liver problems or hepatitis? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| i. Diabetes, pancreas disorder, gallstones, or gallbladder troubles, goiter or thyroid trouble or hernia? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| j. Kidney problems, kidney stones, nephritis, kidney disease, urinary tract disorder or the need for dialysis? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| k. Any problems with male or female organs, prostate or gynecological problems or infertility? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| l. Allergies, hay fever, sinus infection or a disorder of the eyes, ear, nose or throat? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| m. History of an organ transplant, on a transplant waiting list or has a transplant been suggested? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 4. Have you or any of your dependents been told that you may need a procedure, treatment, test, therapy or surgery in the future? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 5. Have you or any of your dependents smoked or used tobacco products within the last 2 years? | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Explanation of YES Responses. Attach a separate sheet of paper if necessary.									
Quest #	Name of Individual	Diagnosis/ Condition	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized (Y/N)	Surgery (Y/N)	Recovered (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

Authorization

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. *KRS § 304.47-030(1)*

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. *IC § 35-43-5-3.4; TCA § 56-53-111(b)(1)(A)*. It is additionally a crime to knowingly or intentionally obtain, possess, transfer, or use the identifying information of another person with intent to harm or defraud another person or entity, including with the intent to fraudulently obtain or attempt to obtain money, credit, goods, services or medical information in the name of another person without that person's consent. Penalties include imprisonment, fines and denial of insurance benefits.

KRS § 514.160; IC § 35-43-5-3.5; TCA § 39-14-150.

Signature _____
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Date _____