QualChoice® HEALTH INSURANCE

Group Life Insurance Health Statement

SECTION I. EMPLOYEE INFORMATION

Full Legal Name (LAST, FIRST)				**Social Security Number**
Street Address	**City**	**State**	**Zip**	**Phone Number**
Date of Birth (MM/DD/YYYY)	**Group Name**	**Group #**		

SECTION II: HEALTH INFORMATION

You must provide the following health information to obtain the requested insurance coverage if: (1) you are required by QualChoice to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) your application for group life insurance coverage is being made more than 31 days after you originally became eligible for coverage. Please answer every question and complete every space. If applicable, complete for spouse and child(ren) if applying for Voluntary Life Insurance Coverage.

List below the name and address of the doctor or facility that has your medical records.

Employee's Doctor	
Address	
Spouse's Doctor	
Address	
Child's Doctor	
Address	

	Height	Weight	Have you gained/lost more than 20 pounds in the last year?	If YES, indicate below amount gained/lost:		EXPLAIN BELOW
Employee			☐ YES ☐ NO	Pounds Gained	Pounds Lost	
Spouse			☐ YES ☐ NO	Pounds Gained	Pounds Lost	

Check YES or NO for each of these questions and give details for any YES answers on Page 2. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Within the past 10 years has the proposed insured: a. Had an application for life or health insurance or for reinstatement thereof, declined or modified?	☐	☐	☐	☐	☐	☐
b. Applied for or received any disability compensation?	☐	☐	☐	☐	☐	☐
c. Flown or intended to fly as a pilot, student, or crew member?	☐	☐	☐	☐	☐	☐
2. Has the proposed insured used tobacco products in the past 12months?	☐	☐	☐	☐	☐	☐
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	☐	☐	☐	☐	☐	☐
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	☐	☐	☐	☐	☐	☐
5. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for: a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	☐	☐	☐	☐	☐	☐
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	☐	☐	☐	☐	☐	☐
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)	☐	☐	☐	☐	☐	☐
d. Drug or alcohol dependency or abuse?	☐	☐	☐	☐	☐	☐
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	☐	☐	☐	☐	☐	☐
7. Have you ever been a patient in a hospital, sanitarium, or institution?	☐	☐	☐	☐	☐	☐
8. Have you ever been absent for a period of five (5) or more consecutive days during the last two (2) years due to sickness or injury?	☐	☐	☐	☐	☐	☐
9. Have you ever had any surgical operations or had surgery advised but not performed?	☐	☐	☐	☐	☐	☐
10. To the best of your knowledge and belief, are you now pregnant?	☐	☐	☐	☐	☐	☐

Give the name and address of your personal physician and the date and reason for your last consultation:

Name of Physician	Address/City/State/Zip	Date	Reason for Consultation

Provide details on previous questions, if any.

QUESTION NO.	NAME	DATE MM	DATE YYYY	Give full details for each question answered "YES", including nature of illness or injury, number of attacks, duration, severity, treatment, results and any other pertinent information	Name and Address of Physician or Hospital

Number of children eligible as defined in the group policy: _____
All eligible children are free of any sickness, disease or injury, as defined in Questions 3 through 9, *except* as follows. Write 'NONE' if all children do not need treatment or are free of impairments.

SECTION III. UNDERSTANDINGS, REPRESENTATIONS AND AGREEMENTS

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group life insurance and that such insurance will not become effective until such application has been approved by QualChoice Life and Health Insurance Company, Inc.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company and Medicare Part A and Part B carrier that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give QualChoice Life and Health Insurance Company, Inc., or their reinsurers any such information. I understand that QualChoice Life and Health Insurance Company, Inc., will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to QualChoice Life and Health Insurance Company, Inc., P.O. Box 25610, Little Rock, AR 72221. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization QualChoice Life and Health Insurance Company, Inc., may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be as valid as the original.

Witness	**Date**	**Signature of Proposed Insured (if below age 15, must be Parent or Guardian)**	**Date**
X		X	

SECTION IV. INSTRUCTIONS

Please mail or fax completed form to:

QualChoice
ATTN: Sales Department
P.O. Box 25610
Little Rock AR 72221

FAX: 501-219-5121

Underwritten by QualChoice Life and Health Insurance Company, Inc.