

GROUP MEDICAL PROFILE

Medical Profile

Employer: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents. (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than \$3,000 been paid in the last 12 months? Yes No

B. Has any employee and/or dependent been hospitalized or had surgery in the last 12 months? Yes No

C. MEDICAL CONDITION

OF EMPLOYEES

- | | |
|--|-----------|
| 1) HIV positive, AIDS, or other immune system disorder | 1) _____ |
| 2) Kidney transplants or liver disorder (excluding kidney stones) | 2) _____ |
| 3) Malignant cancer, including leukemia, within last 3 years | 3) _____ |
| 4) Malignant cancer from the last 4 to 10 years ago | 4) _____ |
| 5) Treatment for stroke, seizures, multiple sclerosis or other serious neurological conditions within last 4 years | 5) _____ |
| 6) Heart attack, congestive heart failure, or serious heart disorder within the last 5 years | 6) _____ |
| 7) Nervous or mental disorder or disabilities requiring inpatient hospitalization within last 5 years
(if yes, next question does not apply for that particular case) | 7) _____ |
| 8) Nervous or mental disorder or disability requiring outpatient treatment only,
including prescription drugs within last 5 years | 8) _____ |
| 9) Alcohol or drug abuse treatment within the last 5 years | 9) _____ |
| 10) Emphysema or tuberculosis | 10) _____ |
| 11) Asthma hospitalization within the last 3 years | 11) _____ |
| 12) Blood including anemia treated with prescription drugs within the last 3 years | 12) _____ |
| 13) Diabetes | 13) _____ |
| 14) Infertility currently under treatment | 14) _____ |
| 15) Hemophilia or sickle cell anemia | 15) _____ |
| 16) Organ or bone marrow transplant (or awaiting such a transplant) | 16) _____ |
| 17) Are any employees or dependents pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" how many? _____ What trimester? _____ | 17) _____ |
| 18) List of prescribed medication currently used by each employee and/or dependent | 18) _____ |

EE or Dep	Age	Nature of Condition	Dates of Treatment	Name of Medication	Dosage	\$ Amount of Prior Claims	Prognosis / Current Treatment

The information on this form is designed to expedite your proposal request and provide you with a more accurate quotation. The prospective applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please print)	Prospective Applicant Signature (Optional)	Date
Producer Signature	Date	

Please Fax this completed form to: