

### Health Questionnaire - for Groups

GENDER OF EMPLOYEE	DATE OF BIRTH	HEIGHT ft      in	WEIGHT lbs
THIS APPLICATION IS BEING MADE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY DEPENDENTS <input type="checkbox"/> BOTH			
IF APPLICABLE TO DEPENDENTS, PLEASE COMPLETE THE FOLLOWING:			
Gender of Dependent	Relationship	Date of Birth	Height                      Weight

All of the following questions must be answered with respect to each person for whom you are applying for coverage. (A) Has anyone listed on this application EVER had medical advice, treatment or do you know or have reasons to know of health problems in regard to the following? CHECK YES OR NO. This information will be used to evaluate medical risk, not eligibility for coverage

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	A. NERVOUS - Brain disease; stroke, epilepsy-seizures, fainting or dizzy spells; cerebral palsy; other nervous system disorders.
<input type="checkbox"/>	<input type="checkbox"/>	B. PSYCHIATRIC - Psychiatric counseling; marriage counseling, family therapy; addition to narcotics, barbiturates, amphetamines, or other drug dependency, nervous or mental disorders; alcoholism.
<input type="checkbox"/>	<input type="checkbox"/>	C. GENITOURINARY SYSTEM - Kidney, prostate, bladder, menstrual or other female disorders.
<input type="checkbox"/>	<input type="checkbox"/>	D. MUSCULOSKELETAL - Arthritis; rheumatism, bodily deformity; congenital abnormality; ruptured disc; or any muscle disorders.
<input type="checkbox"/>	<input type="checkbox"/>	E. CARDIOPULMONARY - High blood pressure; heart disease; circulatory disorders; disease; tuberculosis.
<input type="checkbox"/>	<input type="checkbox"/>	F. DIGESTIVE SYSTEM - Mouth; ulcers; disease or stomach; gall bladder; colon or intestines; hernia; rectal disorders.
<input type="checkbox"/>	<input type="checkbox"/>	G. EYE, EAR, NOSE, THROAT - Asthma; sinus; allergies; disease or nose or ears; disease of throat or tonsils; impairment of sight or hearing.
<input type="checkbox"/>	<input type="checkbox"/>	H. INCAPACITATION - Physical handicaps; mental retardation; disabled or incapacitated as defined by Medicare.
<input type="checkbox"/>	<input type="checkbox"/>	I. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Kaposi Sarcoma, Pneumocystis, Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)
<input type="checkbox"/>	<input type="checkbox"/>	J. Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts.
<input type="checkbox"/>	<input type="checkbox"/>	K. Tumor or mass, cancer/liver disorder; hepatitis; thyroid disorders; blood disease; hemophilia; diabetes; skin disorders; infections or any other medical advice, examination, not disclosed above?
<input type="checkbox"/>	<input type="checkbox"/>	L. Is anyone listed on this application pregnant? If yes, what is the expected due date? _____
<input type="checkbox"/>	<input type="checkbox"/>	M. Been advised to undergo a surgical operation or procedure within the next 6 months?
<input type="checkbox"/>	<input type="checkbox"/>	N. Are you currently taking prescription drugs? If yes, please list on a separate sheet and attach.

<b>Name and Complete address of Doctor(s) seen by you within last 2 years</b>	<b>Name and Complete address of Doctor(s) seen by you within last 2 years</b>

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**COMPLETE THIS SECTION IF ANY QUESTIONS WERE ANSWERED "YES" TO ANY OF THE ABOVE**

Person Treated	Name of Illness	Type of Treatment	Treatment Dates From                      To	Name and Address of Attending Physician

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET