Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Filing at a Glance

Company: The Mega Life and Health Insurance Company

Product Name: eApp (03/09) SERFF Tr Num: MGCC-126107569 State: Arkansas
TOI: H15I Individual Health - SERFF Status: Closed- State Tr Num: 42367

Hospital/Surgical/Medical Expense Disapproved

Sub-TOI: H15I.001 Health - Co Tr Num: CH/MG-25098-EAPP State Status: Disapproved-Closed

Hospital/Surgical/Medical Expense (03/09) AR (FOR MEGA)

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Chalon Ybarra, Courtney Disposition Date: 09/30/2009

Sharp, Jaime Butler

Date Submitted: 05/08/2009 Disposition Status: Disapproved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: eApplication (CH/MG Combo (03/09))

Status of Filing in Domicile:

Project Number: eApp (03/09)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 09/30/2009 Explanation for Other Group Market Type:

State Status Changed: 09/30/2009

Deemer Date: Created By: Chalon Ybarra

Submitted By: Chalon Ybarra Corresponding Filing Tracking Number:

Filing Description:

Electronic Application Form CH/MG-25098-eAPP (03/09) AR

Company and Contact

Filing Contact Information

Chalon Ybarra, Compliance Analyst II chalon.ybarra@healthmarkets.com

9151 Boulevard 26 817-255-5487 [Phone]

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

The Mega Life and Health Insurance Company CoCode: 97055 State of Domicile: Oklahoma

9151 Boulevard 26 Group Code: 264 Company Type: Health

North Richland Hills, TX 76180 Group Name: State ID Number:

(817) 255-3100 ext. [Phone] FEIN Number: 59-2213662

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No

Fee Explanation: \$20.00 per form x 1 form = \$20.00

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

The Mega Life and Health Insurance Company \$20.00 05/08/2009 27744985

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Correspondence Summary

Dispositions

Status Created By Created On Date Submitted

Disapproved Rosalind Minor 09/30/2009 09/30/2009

Objection Letters and Response Letters

Objection Letters Response Letters

Status Created By Created On Date Submitted Responded By Created On Date Submitted

Pending Rosalind Minor 05/15/2009 05/15/2009

Industry Response

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Disposition

Disposition Date: 09/30/2009

Implementation Date: Status: Disapproved

Comment:

Since we have not had a response to our Objection Letter of 5/15/09, this submission is being disapproved.

Rate data does NOT apply to filing.

 SERFF Tracking Number:
 MGCC-126107569
 State:
 Arkansas

 Filing Company:
 The Mega Life and Health Insurance Company
 State Tracking Number:
 42367

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Health - Actuarial Justification	Disapproved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Cover Letter	Disapproved	Yes
Supporting Document	List of Forms	Disapproved	Yes
Supporting Document	Variability Statement	Disapproved	Yes
Form	Application	Disapproved	Yes

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/15/2009 Submitted Date 05/15/2009

Respond By Date Dear Chalon Ybarra,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, CH/MG-25098-eAPP (03/09) AR (Form)

Comment: The name of the Underwriter should be on the first page of the application and more prominent than "Health Markets".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Form Schedule

Lead Form Number: CH/MG-25098-eAPP (03/09) AR

Schedule	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Item	Number			Data		
Status						
Disapprove	CH/MG-	Application/ Application	Initial		50.000	CHMG-
d	25098-	Enrollment				25098-eApp
09/30/2009	eAPP	Form				_0309_
	(03/09) AR					AR.pdf



PRIMARY APPLICANT: [John Doe]
[PRODUCER NAME: [Bobby Greatagent]]

[Date: [MM/DD/YY]]

APPLICATION SUMMARY

APPLICANT INFORMATION

Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.

[APPLICANT DEMOGRAPHICS]

First Name: [John] Middle Initial: [C]

Last Name: [Doe] Suffix:

Physical (no PO Box) Address: [1234 Anywhere St]

Apt or Suite Number: [Apt. 123]

City: [Ft. Worth]

State: [Texas] **ZIP Code**: [12345-[6789]]

County: [Tarrant] {this will auto-generate based on Physical Address Zip Code and State}

Home Phone Number: [123-456-7890] Cell Phone Number: [456-123-7899]

Daytime Phone Number: [098-765-4321] Fax Phone Number: [987-654-4321]

Preferred Contact

Number: [Daytime]

Best Time to Call: [AM] Email: [john.doe@email.com]

Marital Status: ● Married ○ Single [○ Common Law {this will only be an option IF the state recognizes this as

a legal marriage/unity}] [O Domestic Partnership {this will only be an option IF the state

recognizes this as a legal marriage/unity}]

SSN: [123-45-6789] **Gender**: ● Male ○ Female

Date of Birth: [08/04/1976] **Age:** [32] {auto-calculation based on "Date of Birth" and today's

date}

Birthplace: [state] Height: [6 feet 2 inches]

Other: [i.e. Russia] Weight: [220]

Occupation/Duties: [none]

Is Applicant a U.S. Citizen? • Yes • No

[Mailing Address]

Mailing Address: [1234 Anywhere St]

Apt or Suite Number: [Apt. 123]

City: [Ft. Worth]

State: [Texas] **ZIP Code**: [12345-[6789]]

[Coverage Information]

Request for Special Effective Date: [01/15/2009]

[Additional Detail

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans)

1. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? ○ Yes ● No



CH/MG-25098-eAPP (03/09) AR

	lity, in the process of adoptic	if not proposed for insurance) being tested for or receiving n or surrogacy (with anyone, whether or not this person is				
3. Has the Applicant used to	3. Has the Applicant used tobacco products in the past twelve (12) months? ○ Yes ● No					
4. Has the Applicant ever ha O Yes ● No	d or does the Applicant curre	ntly have a suspended or revoked Driver's License?				
5. Has the Applicant ever re	ceived any citations for driving	g while under the influence (e.g. DWI or DUI)? • Yes • No				
6. Has the Applicant ever be	en convicted or prosecuted fo	r any criminal activity? ○ Yes • No]				
[Income and Disability Detail						
{The following questions are Only Disability Income Ins	only applicable if Primary or Sp surance Certificate) (Form # [259	ouse Applicant(s) chose the "Income Protection Plan" (Accident-16-C]) or the "Income Protection Plus Plan" (Disability Income ; not applicable for Dependent Applicant(s).}				
1. Does the Applicant curre policy)? ○ Yes ● No]	ently have Disability Income I	nsurance (either through your employer or as an individua				
FAMILY MEMBERS						
[Family Member 1]						
First Name:	[Jane]	Middle Initial: [A]				
Last Name:	[Doe]	Suffix:				
SSN:	[123-45-6789]					
Date of Birth:	[08/19/1978] Age	e: [30] {auto-calculation based on "Date of Birth" and today's date}				
Relationship	[spouse] Gende					
Height: Birthplace:	[5 feet 4 inches] Weigh [state] Othe	• •				
	Occupation/Duties: [working licant a U.S. Citizen? ● Yes nary Applicant? ● Yes ○ N	O No				
		ental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/o 023-IP (5/07) AR) only (they are applicable for all other plans}				
1. Has the Applicant used to	bacco products in the past tw	elve (12) months? ○ Yes • No				
2. Has the Applicant ever ha ○ Yes ● No	d or does the Applicant curre	ntly have a suspended or revoked Driver's License?				
3. Has the Applicant ever re O Yes ● No	ceived any citations for driving	g while under the influence (e.g. DWI or DUI)?				
4. Has the Applicant ever be	en convicted or prosecuted fo	r any criminal activity? ○ Yes ● No]				
[Income and Disability Detail						
Only Disability Income Ins	surance Certificate) (Form # [259	ouse Applicant(s) chose the "Income Protection Plan" (Accident- 16-C]) or the "Income Protection Plus Plan" (Disability Income ; not applicable for Dependent Applicant(s).}				
1. Does the Applicant curre	ently have Disability Income I	nsurance (either through your employer or as an individua				

2



policy)? ○ Yes • No]					
[Family Member 2]					
First Name:	[Baby]		Middle Init	tial: [B]	
Last Name:	[Doe]			ffix:	
SSN:			Ou.		
Date of Birth:	-	Age:	[2] {auto-calculat	tion based	d on "Date of Birth" and today's
		· ·	date}		•
Relationship	[dependent]	Gender:	Male ○ Fem	nale	
Height:	[3 feet 1 inches]	Weight:	[42]		
Birthplace:	[TX]	Other:	[i.e. Russia]		
	Occupation/Duties				
	licant a U.S. Citizen?		ON C		
Same address as Prir			, "	0.1/	• No
la Dam			on/guardianship?		● No
is Depo	endent Applicant bet			YesYes	
			ull-time student? Name of School:		Jniversity]]
		[[ii ies ,]	Explain:	[details]	
Is this Applicant incar	nahle of self-sustaini	ina employm		[uctails]	
mental retardation of					
	Primary Applicant fo			O Yes	● No
	,, ,				
[Additional Detail					
${ar{t}}$ The following questions are l	NOT applicable for the	e "MEGA Den	ntal Plan" (Dental In	nsurance F	Policy, form 26099-IP (1/08)) and/or
the "MEGA Vision Plan" (Vision Insurance Polic	cy, form 2602	23-IP (5/07) AR) on	ly (they ar	re applicable for all other plans}
1. Has the Applicant used to	nhacco products in t	he nast twel	ve (12) months?	O Yes	■ No
1. Has the Applicant used to	obacco products in t	ile past twei	ve (12) months:	J 103	140
2. Has the Applicant ever ha ○ Yes ● No	ad or does the Applic	cant current	y have a suspend	led or rev	oked Driver's License?
3. Has the Applicant ever re	ceived any citations	for driving	while under the in	fluence (e	e.g. DWI or DUI)? • Yes • No
4. Has the Applicant ever be	en convicted or pro	secuted for	any criminal activ	rity? OY	′es •No]
<u> </u>	•		-	-	

CHOICE OF COVERAGE

The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit (Catastrophic Expense Preferred	[John Doe]	[Calendar Year Deductible: [\$2,500 per Person, In-Network / \$5,000 per	[\$\$\$\$.\$\$] [Incl.]
Provider Organization (PPO)		Person, Out-of-Network	[IIIOI.]
Policy) (Form # [CH-26210 PPO-IP		\$5,000 per Family, In-Network / \$10,000 per	
(03/09) AR] (EFIL)]		Family, Out-of-Network]]	
		Coinsurance:	
		[70% In-Network / 50% Out-of-Network]	
		Calendar Year / Lifetime Maximum:	
		[\$1,000,000 / \$2,000,000]	
		[Coinsurance Maximum	
		(per Calendar Year):	
		[\$2,500 per Person, In-Network / \$5,000 per	



		Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per Family, Out-of-Network]]	
		Option of Network: [023-Private Health Care Systems (PHCS)]	
[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)]	[Jane Doe] [Baby Doe]	[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible: [\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]]	[\$\$\$\$.\$\$] [Incl.]
(5) 12/]		Coinsurance: [70% In-Network / 50% Out-of-Network]	
		Lifetime Maximum: [\$500,000]	
		Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount: [\$7,500 / \$3,000]	
		Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount: [\$3,750 / \$1,000]	
		Option of Network: [023-Private Health Care Systems (PHCS)]	
[Physician Office Services Benefit Rider (Form # CH-26223-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (per Person, per Visit): [\$25 In-Network / \$50 Out-of-Network]	[\$\$\$\$.\$\$] [Incl.]
		Visit Limitation (per Person, per Calendar Year): [2]	
[Outpatient Accident Expense Benefit Rider (Form # CH-26221-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (In-Network and Out-of-Network): [\$50]	[\$\$\$\$.\$\$] [Incl.]
		Maximum Benefit Amount (per Person, per Calendar Year): [\$500]	
[Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	[Copayment][Facility Fee] (per Person, per Visit): [\$150 In-Network / \$300 Out-of-Network]	[\$\$\$\$.\$\$] [Incl.]
(1 51111 # 511-25224-11X (55155))]		[Combined Visit Limitation (per Person, per Calendar Year): [15]]	



[John Doe] [Jane Doe] [Baby Doe]	[[Copayment][Facility Fee]	[\$\$\$.\$\$]
	[\$250 III-NCWOIK / \$500 Out-of-NetWork]]	[Incl.]
	[Maximum Benefit Amount (per Person, per Day): [\$500]]	
	[Maximum Benefit Amount (per Person, per Calendar Year): [\$2,500]]	
[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$\$.\$\$] [Incl.]
[John Doe] [Jane Doe] [Baby Doe]	Guarantee Level: [24] months	[\$\$\$\$.\$\$] [Incl.]
[John Doe] [Jane Doe] [Baby Doe]	Maximum Benefit Amount (per pregnancy/childbirth): [\$1,000]	[\$\$\$\$.\$\$] [Incl.]
[John Doe]	Maximum Benefit (per person, Calendar Year): [\$1,500]	[\$\$\$\$.\$\$] [Incl.]
	Generic / Brand Drug Deductible (per Person, per Calendar Year): [[\$0 / \$250]]	
	Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply	
	Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$15] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$45] copayment Brand Preferred Drugs, [90] day supply	
	[Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Baby Doe]	[Maximum Benefit Amount (per Person, per Calendar Year): [\$2,500]] [John Doe] [Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Jane Doe] [Jane Doe] [Jane Doe] [S1,000] [John Doe] [S1,500] [John Doe]



		Brand Non-Preferred Drugs, [90] day supply discount: [25%]	
[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]]	[Jane Doe] [Baby Doe]	Maximum Benefit (per Person, per Calendar Year): [\$500]	[\$\$\$\$.\$\$] [Incl.]
		Deductible (per Person, per Calendar Year): [\$250]	
		Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] [\$10] [\$15] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$20] [\$25] [\$30] copayment Brand Name Drugs, [30] day supply discount: [25%]	
		Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$10] [\$20] [\$30] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$40] [\$50] [\$60] copayment Brand Name Drugs, [90] day supply discount: [25%]	

The following Certificates/Policies are i	underwritten by Th	e MEGA Life and Health Insurance Company:	
[MEGA Vision Plan (Vision	[John Doe]	NETWORK:	[\$\$\$\$.\$\$]
Insurance Policy) (Form #	[Jane Doe]	Deductible: [\$0]	[Incl.]
[(26023-IP (5/07) AR)]) (VSIN)]	[Baby Doe]	Comprehensive Eye Exam: [100%]	
		Corrective Spectacle Lenses: [100%]	
		Corrective Contact Lenses (Non-Disposable or	
		Disposable): [\$40]	
		Corrective Contact Lenses (Therapeutic):	
		[100%]	
		Frames: [Not Covered]	
		Contact Lens Fitting: [Not Covered]	
		Follow-Up Visits: [Not Covered]	
		NON-NETWORK:	
		Deductible: [\$0]	
		Comprehensive Eye Exam: [\$30]	
		Corrective Spectacle Lenses: [75%]	
		Corrective Contact Lenses (Non-Disposable or	
		Disposable): [\$30]	
		Corrective Contact Lenses (Therapeutic): [75%]	
		Frames: [Not Covered]	
		Contact Lens Fitting: [Not Covered]	
		Follow-Up Visits: [Not Covered]	
[MEGA Bronze (Dental Insurance	[John Doe]	[BRONZE (Option A-Diagnostic & Preventive):	[\$\$\$.\$\$]
Policy) Form # [26099-IP (1/08)]	[Jane Doe]	Deductible: [\$0]]	[Incl.]



(DTLB)]	[Baby Doe]		
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [\$10,000]	[\$\$\$\$.\$\$] [Incl.]
[Income Protection (Accident- Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe]	Monthly Indemnity Benefit (per disabled person):	[\$\$\$\$.\$\$] [Incl.]
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [White Collar: Yes]	[\$\$\$\$.\$\$] [Incl.]
		[Willie Gollar. 166]	
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (Cl01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [\$10,000]	[\$\$\$\$.\$\$] [Incl.]
[MEGA Accident Advantage (Accidental Injury Only Insurance Certificate) (Form # [26038-C]) (ASLG)]	[John Doe]	Accidental Injury Benefit Amount, per person, per year: [\$5,000]	[\$\$\$\$.\$\$] [Incl.]
[Accident Expense Insurance Plan (Accident Catastrophic Expense Plan Certificate of Insurance) (Form # [25314]) (IA08)]	[Jane Doe] [Baby Doe]	Deductible, per person, per occurrence: [\$2,400] Maximum Benefit, per person, per occurrence: [\$6,000]	[\$\$\$\$.\$\$] [Incl.]
		Coinsurance: [50%]	
[Accident Expense Benefit Rider (Form # [25096])]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per injury: [\$0]	[\$\$\$\$.\$\$] [Incl.]
		Maximum Benefit, per injury [\$600]	
[Direct Benefit (Hospital Confinement Indemnity Certificate) (Form # [25874-C]) (DB01)]	[John Doe] [Jane Doe] [Baby Doe]	Daily Benefit Amount (per person): [\$100]	[\$\$\$\$.\$\$] [Incl.]



[023-Private Health Care Systems		[\$\$\$\$.\$\$]
(PHCS)]		[Incl.]
[Certificate][Policy] Fee		[\$\$\$.\$\$]
		[Incl.]
	Total Estimated Recurring Payment:	[\$\$\$\$.00]
	Total Initial Payment:	[\$\$\$\$.00]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.

{The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)
APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code:** [09876-5432]

[Date: [MM/DD/YY]]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited

ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]

Reason(s)? [reason]

Result(s)? [results]

Recommendation(s)? [recommendations]



APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]

Physician/Specialist Name: [Baby Doctor, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC] City: [My Town]

> [My State] State: **ZIP Code**: [09876-5432]

> > Middle Initial: [A]

Middle Initial: [B]

Suffix:

Percentage: [XXX%]

[Date: [MM/DD/YY]]

Suffix:

Percentage: [XXX%]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

> Center/Hospital? [MM/YYYY] Reason(s)? [reason] Result(s)? [results]

Recommendation(s)? [recommendations]

{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.}

BENEFICIARY INFORMATION

John Doel Beneficiary Information Details

BENEFICIARY 1

First Name: [Jane]

Last Name: [Doe]

Beneficiary Relationship: [Wife]

Other:

[Fabulous] City: State: [State]

[12345-9876] Zip:

BENEFICIARY 2

First Name: [Baby]

Last Name: [Doe]

Beneficiary Relationship: [Son]

Other:

Citv: [Fabulous] State: [State]

Zip: [12345-9876]

PRIOR COVERAGE

(The following question is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

MEDICARE/MEDICAID

Is any Applicant eligible for or currently covered under Medicare or Medicaid? • Yes

[If "Yes", who? Reason

> O [John Doe] [Financial] [Medical] O [Jane Doe] [Financial] [Medical] O [Baby Doe] [Financial] [Medical]

CURRENT HEALTH INSURANCE

During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded? ○ Yes ● No



Does any Applicant currently have health insurance or has any Applicant had health insurance within the past 12 months? ○ Yes ● No [If "Yes", has coverage been in force within the past 60 days? ○ Yes ○ No] [If "No", date of cancellation: [MM/YYYY]]
CURRENT LIFE INSURANCE Does any Applicant currently have life insurance or annuities? ○ Yes ● No
Will the insurance applied for replace or otherwise reduce in value any life insurance or annuities now in force? ○ Yes ● No

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans)

MEDICAL QUESTIONS Have you or any Applicant EVER had symptoms, been diagnosed, received medical advice or been treated for: 1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? O Yes ● No [If "Yes", is it professionally or for recreation? O Professionally O Recreationally] O [John Doe] O [Jane Doe] Select all Applicants this question applies to: O [Baby Doe] 2. Heart or Cardiovascular Conditions/Disorders including but not limited

to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system? O Yes ● No Select all Applicants this question applies to: O [John Doe] O [Jane Doe] O [Baby Doe] 3. Endocrine Disorders including but not limited to - Diabetes (high blood

sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity? O Yes ● No Select all Applicants this question applies to: O [John Doe] O [Jane Doe]

O [Baby Doe] O Yes ● No 4. Blood Disorders including but not limited to - Blood or spleen disorder,

> Select all Applicants this question applies to: O [John Doe] O [Jane Doe]

5. Gynecological Disorders including but not limited to - male or female reproductive organ disorder or disease, including breast disorder or

including anemia, leukemia, high cholesterol, or hyperlipidemia?

augmentation? O Yes ● No

O [Baby Doe]

Select all Applicants this question applies to: O [John Doe] O [Jane Doe] O [Baby Doe]

6. Cancer / Tumor or any benign or malignant growths, including but not O Yes ● No limited to - Cancer, cyst, tumor, or neoplasm?

O [John Doe] O [Jane Doe]

[Date: [MM/DD/YY]]

Select all Applicants this question applies to:



	○ [Baby Doe]
7. Respiratory Disorders including but not limited to - Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems?	○ Yes • ○ No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
8. Urinary Tract Disorders including but not limited to - Kidney, bladder, urinary tract, stones, or prostate disorders?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
9. Digestive Tract Disorders including but not limited to – GERD (gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis,	C [Baby Boe]
hepatitis, or pancreatitis?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
12. Skin Disorders including but not limited to - Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
14. Complications of Pregnancy including but not limited to - Cesarean section?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]



17. Connective Tissue Disorders including but not limited to - Hodgkin's or	○ [Baby Doe]
Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe] ○ [Baby Doe]
18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe] ○ [Baby Doe]
19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe] ○ [Baby Doe]
20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of	C [Baby Doe]
use of any limbs?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an	
AIDS-related test?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had any other medical or surgical advice, hospitalizations, treatment, operations, or	
testing?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s),	
including any which were not filled?	O Yes ● No
[If "Yes", what condition(s) is the prescribed medication for?]	[conditions]
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
22c. Recent Medical Treatment – Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment, or had such that has not yet been completed?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe] ○ [Baby Doel]



The following questions are only applicable if Applicant(s) chose the "Critical Care/Plus Plai" Major Organ Transplant Certificate) (Form # [25936-C])}	n" (Specified Disease/Condition Or
23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or	
	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas,	
heart/lung combined or bone marrow?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ,	
coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]

PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT] 1st Payment: [\$\$\$.00] O VISA O MasterCard **Credit Card Type:** Name of Cardholder as it appears on the card: [John Doe] **Relationship of Payor to Primary Applicant:** [self] [Reason for Payor Being Different than Applicant: [reason]] Type of Card: [O Credit O Debit] **Account Type:** [Personal] **Credit Card Number:** [5525-XXXX-XXXX-XX54] **Expiration Date:** [01/10] Cardholder's Billing Address Line 1: [address] Cardholder's Billing Address Line 2: City: [city] State: [TX] Zip: [zip code] **Cardholder's Phone Number:** [phone number]

[ONGOING PAYMENTS]

Ongoing Payments: [● Checking Account Electronic Fund Transfer (EFT)

Savings Account Electronic Fund Transfer (EFT)

O Bill Me]

Payment Mode: [● Monthly ○ Quarterly ○ Annually]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx088]
Confirm Bank Routing Number: [xxxxx9485]
Confirm Bank Account Number: [xxxxx088]

Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]



Primary Name on Bank Account: [John C Doe]
Relationship of Payor to Primary Applicant: [relationship]
[Reason for Payor Being Different than Applicant: [reason]]

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE - [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE - [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

FOR HOME OFFICE USE ONLY

Special Request(s): [office use only text] {only agent allowed to fill in text here}

[Date: [MM/DD/YY]]

[Association] Membership: [NASE Premiere] {system-generated} [Association] Membership Number: [0123456789] {system-generated} [O9/15/2008] {system-generated} [O6/15/2008] {system-generated}

Lead ID: [1234-ABC]

Market Type: [Association Group (I)]



ELECTRONIC S	SIGNATURE – [Bobby Gre	eatagent]			
Do you have a	ID: [123456789] ny knowledge or reason to e insurance or annuities?		proposed Insured(s) is in	ntending to replace	e or otherwise reduce in value
electronically s	ign this application.		3 , 3		ed statement and my intent to have accurately recorded all
OR					
•	o the best of my knowledge pplication.	e and belief the A	Applicant(s) has/have pe	rsonally recorded	the answers to each question
Please type yo First Name:	ur name in the spaces belo [Bobby]	w to electronical MI: [B]		[Greatagent]	Suffix:
Please re-type First Name:	your name in the spaces be [Bobby]	elow to confirm y MI: [B]	our signature. Last Name:	[Greatagent]	Suffix:

END OF APPLICATION FOR INSURANCE

[Date: [MM/DD/YY]]

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Disapproved 09/30/2009

Comments:

Attachments:

AR.MEGA CH.MG-25098-eAPP _0309__Cert Compl Rule-Reg19.pdf

AR.MEGA CH.MG-25098-eAPP _0309__flesch.pdf

Item Status: Status

Date:

Satisfied - Item: Application Disapproved 09/30/2009

Comments:

This submission is for a new application.

Item Status: Status

Date:

Bypassed - Item: Health - Actuarial Justification Disapproved 09/30/2009

Bypass Reason: N/A - Application only filing

Comments:

Item Status: Status

Date:

Bypassed - Item: Outline of Coverage Disapproved 09/30/2009

Bypass Reason: N/A - Application only filing

Comments:

Item Status: Status

Date:

Satisfied - Item: Cover Letter Disapproved 09/30/2009

Comments:

Attachment:

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR MEGA)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)
AR.MEGA CH.MG-25098-eAPP _0309__Cover Letter.pdf

Item Status: Status

Date:

Satisfied - Item: List of Forms Disapproved 09/30/2009

Comments:

Attachment:

AR.MEGA CH.MG-25098-eAPP _0309__List of Forms.pdf

Item Status: Status

Date:

Satisfied - Item: Variability Statement Disapproved 09/30/2009

Comments:

The attachment exceeded the maximum size limit allowed by SERFF; therefore, it was split into two separate files.

Attachments:

VAR STMT CHMG-25098-eApp _0309_ AR - File 1 of 2.pdf _VAR STMT_ CHMG-25098-eApp _0309_ AR - File 2 of 2.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The MEGA Life and Health Insurance Company

Form Number(s):
CH/MG-25098-eAPP (03/09) AR
I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.
Susan E. Dew
Signature of Company Officer
Susan Dew
Name
Senior Vice President, Associate General Counsel and Chief Compliance Officer
Title
May 8, 2009
Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Application

Form Number: CH/MG-25098-eAPP (03/09) AR

Flesch Reading Ease Score: 50

Susan E. Dew

Susan Dew

Senior Vice President, Associate General Counsel and Chief Compliance Officer The MEGA Life and Health Insurance Company

May 8, 2009

Date



P 817-255-5487 **F** 817-255-8153 www.HealthMarkets.com 9151 Boulevard 26 North Richland Hills Texas, 76180

May 8, 2009

Commissioner Jay Bradford Arkansas Insurance Department Life and Health Division 1200 West Third Street Little Rock, AR 72201

RE: The MEGA Life and Health Insurance Company

NAIC No. 264-97055 FEIN No. 59-2213662

SERFF Tracking # MGCC-126107569

Form Number: Description:

CH/MG-25098-eAPP (03/09) AR Application for Insurance

<u>Supporting Documentation (FOR INFORMATIONAL PURPOSES)</u>
(VAR STMT) CH/MG-25098-eAPP (03/09) AR Statement of Variability

Dear Commissioner Bradford:

The above referenced form, **CH/MG-25098-eAPP (03/09) AR**, is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

Upon approval, the enclosed Application form CH/MG-25098-eAPP (03/09) AR is intended to be used to solicit coverage by electronic means with our previously approved group/individual ancillary plans, as well as the following individual health plans underwritten by our sister company, The Chesapeake Life Insurance Company, forthcoming under separate cover:

COMPANY FORM NUMBER	DESCRIPTION
CH-26210 PPO-IP (03/09) AR	Catastrophic Expense Preferred
	Provider Organization (PPO) Policy
CH-26220 PPO-IP (03/09) AR	Limited Benefit Basic Medical-
, , ,	Surgical Expense Preferred Provider
	Organization (PPO) Policy

For the Department's review, enclosed is a **"FORMS LISTING"** showing exactly what previously approved certificate/policy forms underwritten by The MEGA Life and Health Insurance Company we intend to solicit coverage under using application form CH/MG-25098-eAPP (03/09) AR.

This application is concurrently being filed for review and approval under our sister company, The Chesapeake Life Insurance Company. It is our hope that this application may also be used to solicit coverage for various group/individual health and ancillary plans that may be submitted to the Department for review and approval in the future.

Additionally, enclosed is a very detailed **Statement of Variability** version of this Application form, form number (VAR STMT) CH/MG-25098-eApp (03/09) AR. This version contains extensive information reflecting every possible question and product scenario that could be presented through the electronic application process. This form is intended to be viewed as supporting documentation, for informational purposes. We understand that this is a lot of information, so please do not hesitate to contact me, Chalon Ybarra, directly (collect, if preferred) at (817) 255-5487, or via email at chalon.ybarra@healthmarkets.com. I am eager to discuss any questions you may have regarding the information enclosed herewith.



Upon approval, this form will be used electronically via an internet-based system currently under development by outside contractor Connecture, Inc. To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

Your assistance in this matter is greatly appreciated.

Sincerely,

Chalon Ybarra

Product Compliance Analyst II Compliance Department

Chalon ybana

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180 **P** (817) 255-5487 • **F** (817) 255-8153 chalon.ybarra@HealthMarkets.com • www.HealthMarkets.com

The MEGA Life and Health Insurance Company FORMS LISTING

List of policy/certificate forms currently approved by Arkansas that CH/MG-25098-eAPP (03/09) AR may be used to solicit coverage under:

Form Number	Deemer/Approval Date	State Tracking #
25314	08/02/1996	
25874-C	10/13/1999	
25915-C	03/30/2001	
25916-C	11/08/2000	
25936-C	12/03/2002	
26023-IP (5/07) AR	08/06/2007	35950
26038-C	04/17/2007	35598
26055-IP (5/07) AR	05/25/2007	35951
26099-IP (1/08)	02/20/2008	38184



PRIMARY APPLICANT: [John Doe] [PRODUCER NAME: [Bobby Greatagent]]

APPLICATION SUMMARY					
APPLICANT INFORMATION					
Note: All of the information you pro	ovide is for quoting and	d applicati	on purposes only a	and will be kept confident	al.
la tha Duimana Amaliaant a			NV ON-		
Is the Primary Applicant a	i adult dependent?		Yes O No		
{If "Yes":}					
Hama Dhana Numbar	[402 456 7000]	Call	Dhana Numban	[456 400 7000]	
Home Phone Number: Daytime Phone Number:			Phone Number:	[456-123-7899] [987-654-4321]	
Daytime Phone Number:	[098-765-4321]	гах	Phone Number:	[967-654-4321]	
Is this a child-only applica	ion?		Yes O No		
{If "Yes":}			7103 3110		
{II 163 .f					
f applying for child-only coverage	ne inlease enter the o	oldest chi	ld as the Primary	Applicant and all additi	ional children if
any, on the Family Members pag		oracot orri	na ao ano i minary	Applicant and an additi	ionar omiaron, n
APPLICANT DEMOGRAPHICS	,•-				
First Name	: [Fred]		Middle Init	ial: [C]	
Last Name			Suf		
Physical (no PO Box) Address		t1			
Apt or Suite Number		•			
City					
State			ZIP Co	de: [12345-[6789]]	
County		auto-genei	rate based on Phys	sical Address Zip Code ai	nd State}
•		J	Í	,	,
Home Phone Number	: [123-456-7890]		Cell Phone Numb	er: [456-123-7899]	
Daytime Phone Number			Fax Phone Numb		
Preferred Contact Number					
	[Daytime]				
Best Time to Call			Ema	ail: [john.doe@email.co	om]
				_	-
Marital Status	: O Married O Sing	le [O Cor	nmon Law <i>{this wil</i>	Il only be an option IF the	state recognizes
				artnership {this will only b	e an option IF the
	state recognizes th	nis as a leg	gal marriage/unity}]	
[If "Common Law":					
Is there any legal impedin					
	either party that has	not been	legally terminated	d by death or divorce?	O Yes O No
Are	you living in a husba	and and w	vife relationship e	exclusive of all others?	O Yes O No
				[If "Yes" -	
	Indicate the d			common law marriage:	[MM/DD/YY]
		In	what State did yo	ou reside on that date?	[state]]
A					O Vaa O Na
Are you pres	sented and known th	rougnout	your community	as husband and wife?	O Yes O No
	Ara van lainti	ly roonan	sible for each ath	or's common walfare?	O Vec O No 1
	Are you jointi	y respons	Sible for each oth	er's common welfare?	O Yes O No]
SSN : [12	23-45-6789]	Gender:	• Male O Fem	ale	
33N. [12	-0-70-0100j	Genuel.	- Maie - O I CIII	aic	
Date of Birth: [08	3/04/1994]	Age:	[14] {auto-calcula	ntion based on "Date of Bi	irth" and today's
Date of Birtin. [or		, .gc.	doto)	Dated on Date of Di	and today o



Birthplace: [state] Height: [5 feet 10 inches]

Other: [i.e. Russia] Weight: [150]

Occupation/Duties: [none]

Is Applicant a U.S. Citizen? O Yes O No

[If "No", explain: [explanation]
How long in the U.S.? [months][years]

Residency Status: O Work Permit O Visa O Other]

[If "Visa", Type of Visa: [TYPE]

Expiration Date: [MM/DD/YY] [N/A]] [If "Other", explain: [explanation]]

[Guardian Information]

First Name: [John] Middle Initial: [C]
Last Name: [Doe] Suffix:

Relationship: [Uncle] Phone Number: [123-456-7890]
Mailing Address: [1234 Anywhere St] City: [Ft. Worth]

Apt or Suite Number: [Apt. 123] State: [Texas] ZIP Code: [12345-[6789]]

{If "No":}

[APPLICANT DEMOGRAPHICS]

First Name: [John] Middle Initial: [C]
Last Name: [Doe] Suffix:

Physical (no PO Box) Address: [1234 Anywhere St]

Apt or Suite Number: [Apt. 123]

City: [Ft. Worth]

State: [Texas] **ZIP Code**: [12345-[6789]]

County: [Tarrant] {this will auto-generate based on Physical Address Zip Code and State}

Home Phone Number: [123-456-7890] Cell Phone Number: [456-123-7899]

Daytime Phone Number: [098-765-4321] Fax Phone Number: [987-654-4321]

Preferred Contact

Number: [Davtime]

Best Time to Call: [AM] Email: [john.doe@email.com]

Marital Status: ● Married ○ Single [○ Common Law {this will only be an option IF the state recognizes this as

a legal marriage/unity}] [O Domestic Partnership {this will only be an option IF the state

recognizes this as a legal marriage/unity}]

[If "Common Law":

Is there any legal impediment to your marriage, including but not limited to, a prior marriage of

either party that has not been legally terminated by death or divorce? • O Yes O No

Are you living in a husband and wife relationship exclusive of all others? • O Yes O No

[If "Yes" -

Indicate the date you entered into your common law marriage: [MM/DD/YY]

In what State did you reside on that date? [state]]

Are you presented and known throughout your community as husband and wife? • Yes • No

Are you jointly responsible for each other's common welfare? • Yes • No]



SSN: Date of Birth:	[123-45-6789] [08/04/1976]	Gender: Age:	 Male
Birthplace: Other:	[state] [i.e. Russia]	Height: Weight:	[6 feet 2 inches]
	Occupation/Duties: licant a U.S. Citizen? [If "No", explain: low long in the U.S.? Residency Status: "Visa", Type of Visa: Expiration Date: [If "Other", explain:	[explanation [months][y	ears] ermit O Visa O Other] Y] [N/A]]
Apt or Suite Numl	ess: [1234 Anywhere Sper: [Apt. 123] Sity: [Ft. Worth] ate: [Texas]	St]	ZIP Code : [12345-[6789]]
[Coverage Information] Req	uest for Special Effect	ive Date:	[01/15/2009] {If Applicant does not have a special request, then this will be blank}
			tal Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or 3-IP (5/07) AR) only (they are applicable for all other plans}
father? O Yes O No		·	not proposed for insurance) now pregnant or an expectant son, his or her relationship to the Primary Applicant and the
	lity, in the process of Yes O No		not proposed for insurance) being tested for or receiving or surrogacy (with anyone, whether or not this person is
3. Has the Applicant used to {If "Yes":} [Please provide sr [details]]			ve (12) months? • Yes • No relve months:
4. Has the Applicant ever has O Yes O No {If "Yes":} [Please indicate the [details]]			y have a suspended or revoked Driver's License? spension or revocation.
5. Has the Applicant ever re { <i>If "Yes":</i> } [Please indicate the [details]]		_	while under the influence (e.g. DWI or DUI)? • Yes • No
6. Has the Applicant ever be	en convicted or prose	cuted for a	any criminal activity? O Yes O No



{If "Yes":} [Please describe e [details]]	ach offense and indicat	te the date(s) of prosecution.
[Income and Disability Detail			
Only Disability Income Ins	surance Certificate) (For	rm # [25916	se Applicant(s) chose the "Income Protection Plan" (Accident- S-C]) or the "Income Protection Plus Plan" (Disability Income not applicable for Dependent Applicant(s).}
policy)? • Yes • No		ncome Ins	surance (either through your employer or as an individual
Monthly Bene Elimination Po	ompany name] efit: [\$\$\$\$\$] eriod: [time period] verage: [six months]		
<u>{ f "Yes"}</u> 2. Are you currently disable	d or receiving disabili	ty benefits	? O Yes O No
3. What is your annual gros	s income? [\$\$\$\$\$\$\$	5\$]	
4. How many hours per wee	k do you work? [55] i	Hours	
 5. Tell us about your occupation and describe your specific job duties. Job Description: [route sales manager] Duties: [manage sales on delivery route; establish new clients; deliver goods to existing clients] 6. As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, 			
			over 10 pounds? • Yes • No
FAMILY MEMBERS [Family Member 1]			
First Name: Last Name:	[Jane] [Doe]		Middle Initial: [A] Suffix:
SSN:	[123-45-6789]	_	
Date of Birth:	[08/19/1978]	Age:	[30] {auto-calculation based on "Date of Birth" and today's date}
Relationship Height:	[spouse] [5 feet 4 inches]	Gender: Weight:	O Male ● Female [130]
Birthplace:	[state]	Other:	[i.e. Russia]
Occupation/Duties: [working woman] Is Applicant a U.S. Citizen? O Yes O No [If "No", explain: [explanation]			
	low long in the U.S.? Residency Status:		ermit O Visa O Other]
[If	"Visa", Type of Visa: Expiration Date:	[TYPE] [MM/DD/Y	Y] [N/A]]
Same address as Prin	[If "Other", explain: nary Applicant? ○ Y	[explanation	
			ntal Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or 23-IP (5/07) AR) only (they are applicable for all other plans)



1. Has the Applicant used tobacco products in the past twelve (12) months? • Yes • No {If "Yes":} [Please provide smoking/tobacco history over past twelve months: [details]]
2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License? O Yes O No
<pre>{If "Yes":} [Please indicate the reason(s) for Driver's License suspension or revocation. [details]]</pre>
3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? • Yes • No {//f "Yes":} [Please indicate the date for each DWI and DUI. [details]]
4. Has the Applicant ever been convicted or prosecuted for any criminal activity? • Yes • No {If "Yes":} [Please describe each offense and indicate the date(s) of prosecution. [details]]
Income and Disability Detail] {The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}
1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual policy)? O Yes O No
{If "Yes"}2. Are you currently disabled or receiving disability benefits? ○ Yes ○ No
3. What is your annual gross income? [\$\$\$\$\$\$\$\$]
4. How many hours per week do you work? [55] Hours
5. Tell us about your occupation and describe your specific job duties. Job Description: [route sales manager] Duties: [manage sales on delivery route; establish new clients; deliver goods to existing clients]
6. As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? O Yes O No



[Family Member 2]		
First Name:	[Baby]	Middle Initial: [B]
Last Name:	[Doe]	Suffix:
SSN:	[123-45-6789]	
Date of Birth:	[01/17/2006]	Age: [2] {auto-calculation based on "Date of Birth" and today's date}
Relationship	[dependent]	Gender: ● Male ○ Female
Height:	[3 feet 1 inches]	Weight: [42]
Birthplace:	[TX]	Other: [i.e. Russia]
	Occupation/Duties:	[none]
ls App	licant a U.S. Citizen?	O Yes O No
	[If "No", explain:	
	low long in the U.S.?	
	Residency Status:	
[If	"Visa", Type of Visa:	
	Expiration Date:	
Come address as Driv	[If "Other", explain:	
Same address as Prin		Yes ◯ No <i>{If "No", will ask for Family Member's mailing address}</i> an adoption/guardianship? ◯ Yes ◯ No
le Done		an adoption/guardianship? O Yes O No veen the ages of 19 and 24? O Yes O No
is Dept		pplicant a full-time student? • Yes ○ No
		[If "Yes",] Name of School: [Great University]
	ı	Explain: [details]
Is this Applicant incar	nahla of salf-sustainin	g employment by reason of
		nd chiefly dependent on the
		support and maintenance? • Yes • No
	Timary Applicant for	oupport and maintenance 1 of 100 of 10
[Additional Detail]		
	NOT applicable for the	"MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or
		y, form 26023-IP (5/07) AR) only (they are applicable for all other plans)
		,, , , , , , , , , , , , , , , , , , ,
		e past twelve (12) months? • Yes • No
{If "Yes":} [Please provide sr	noking/tobacco history	over past twelve months:
[details]]		
2 Has the Applicant over he	ad ar daga tha Analia	ant augrently have a augmented or revoked Driver's License?
•	au or does the Applica	ant currently have a suspended or revoked Driver's License?
O Yes O No	o roccon(a) for Driver's	License augnonaion or revocation
	ie reason(s) for Drivers	s License suspension or revocation.
[details]]		
3. Has the Applicant ever re	ceived any citations f	for driving while under the influence (e.g. DWI or DUI)? • Yes • No
{If "Yes":} [Please indicate the		
[details]		
1		
		ecuted for any criminal activity? • Yes • No
{If "Yes":} [Please describe e	each offense and indica	ate the date(s) of prosecution.
[details]]		

CHOICE OF COVERAGE

The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit	[John Doe]	[Calendar Year Deductible:	[\$\$\$.\$\$]



STATEMENT OF VARIABILITY				
(Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (EFIL)]	[Jane Doe] [Baby Doe]	[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per Family, Out-of-Network]	[Incl.]	
		[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network		
		\$10,000 per Family, In-Network / \$20,000 per Family, Out-of-Network]		
		[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network		
		\$15,000 per Family, In-Network / \$30,000 per Family, Out-of-Network]		
		[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network		
		[\$20,000 per Family, In-Network / \$40,000 per Family, Out-of-Network]		
		[\$15,000 per Person, In-Network / \$30,000 per Person, Out-of-Network		
		[\$30,000 per Family, In-Network / \$60,000 per Family, Out-of-Network]		
		[\$20,000 per Person, In-Network / \$40,000 per Person, Out-of-Network		
		[\$40,000 per Family, In-Network / \$80,000 per Family, Out-of-Network]]		
		Coinsurance: [100% In-Network / 70% Out-of-Network] [90% In-Network / 60% Out-of-Network] [80% In-Network / 50% Out-of-Network] [70% In-Network / 50% Out-of-Network]		
		Calendar Year / Lifetime Maximum: [\$1,000,000 / \$2,000,000] [\$1,000,000 / \$4,000,000] [\$2,000,000 / \$8,000,000]		
		[Coinsurance Maximum (per Calendar Year):		
		[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per		
		Family, Out-of-Network]		
		[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network		
		\$10,000 per Family, In-Network / \$200,000 per Family, Out-of-Network]		

[\$10,000 per Person, In-Network / \$20,000



per Person, Out-of-Network \$20,000 per Family, In-Network / \$40,000 per Family, Out-of-Network]

[\$15,000 per Person, In-Network / \$30,000 per Person, Out-of-Network \$30,000 per Family, In-Network / \$60,000 per Family, Out-of-Network]]

Option of Network:

[023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]

[Chesapeake CLASSIC Fit (Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (CFIL)] [John Doe] [Jane Doe] [Baby Doe]

[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:

[\$\$\$\$.\$\$]

[Incl.]

[Date: [MM/DD/YY]]

[\$1,000 per Person, In-Network / \$2,000 per Person, Out-of-Network]

[\$1,500 per Person, In-Network / \$3,000 per Person, Out-of-Network]

[\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]

[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]

[\$3,000 per Person, In-Network / \$6,000 per Person, Out-of-Network]

[\$3,500 per Person, In-Network / \$7,000 per Person, Out-of-Network]

[\$4,000 per Person, In-Network / \$8,000 per Person, Out-of-Network]

[\$4,500 per Person, In-Network / \$9,000 per Person, Out-of-Network]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network] 1

Coinsurance:

[100% In-Network / 80% Out-of-Network] [90% In-Network / 70% Out-of-Network] [80% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network]

Calendar Year / Lifetime Maximum:

[\$1,000,000 / \$2,000,000] [\$1,000,000 / \$4,000,000] [\$2,000,000 / \$8,000,000]

[Coinsurance Maximum (per Period of Treatment):



[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network]]

Option of Network:

[023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]

[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)] [John Doe] [Jane Doe] [Baby Doe]

[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:

[\$\$\$\$.\$\$]

[Incl.]

[Date: [MM/DD/YY]]

[\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]

[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]

[\$3,000 per Person, In-Network / \$6,000 per Person, Out-of-Network]

[\$3,500 per Person, In-Network / \$7,000 per Person, Out-of-Network]

[\$4,000 per Person, In-Network / \$8,000 per Person, Out-of-Network]

[\$4,500 per Person, In-Network / \$9,000 per Person, Out-of-Network]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$5,500 per Person, In-Network / \$11,000 per Person, Out-of-Network]

[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network]]

Coinsurance:

[80% In-Network / 60% Out-of-Network] [70% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network]

Lifetime Maximum:

[\$500,000] [\$1,000,000]

Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount:

[\$7,500 / \$3,000] [\$10,000 / \$4,000] [\$15,000 / \$6,000]



		[\$20,000 / \$8,000]	
		[\$25,000 / \$10,000] [\$30,000 / \$12,000]	
		[\$35,000 / \$12,000]	
		[\$40,000 / \$16,000]	
		[\$50,000 / \$18,000]	
		Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount: [\$3,750 / \$1,000] [\$5,000 / \$2,000] [\$7,500 / \$3,000] [\$10,000 / \$4,000] [\$12,500 / \$5,000] [\$15,000 / \$6,000] [\$17,500 / \$7,000] [\$20,000 / \$8,000] [\$25,000 / \$9,000]	
		[023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]	
[Physician Office Services	[John Doe]	Copayment	[\$\$\$.\$\$]
Benefit Rider (Form # CH-26223-IR (03/09))]	[Jane Doe] [Baby Doe]	(per Person, per Visit): [\$25 In-Network / \$50 Out-of-Network] [\$50 In-Network / \$100 Out-of-Network] [\$75 In-Network / \$150 Out-of-Network]	[Incl.]
		Visit Limitation (per Person, per Calendar Year): [unlimited] [2] [4]	
[Outpatient Accident Expense	[John Doe]	Copayment	[\$\$\$.\$\$]
Benefit Rider (Form # CH-26221-IR (03/09))]	[Jane Doe] [Baby Doe]	(In-Network and Out-of-Network): [\$50] [\$100] [\$150]	[Incl.]
		Maximum Benefit Amount	
		(per Person, per Calendar Year): [\$500] [\$1,000] [\$1,500]	
[Outpatient Speech Therapy,	[John Doe]	[Copayment][Facility Fee]	[\$\$\$.\$\$]
Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[Jane Doe] [Baby Doe]	(per Person, per Visit): [\$50 In-Network / \$100 Out-of-Network] [\$75 In-Network / \$150 Out-of-Network] [\$100 In-Network / \$200 Out-of-Network] [\$150 In-Network / \$300 Out-of-Network]	[Incl.]
		[Combined Visit Limitation (per Person, per Calendar Year): [15] [20] [30]]	



[Continued Care Benefit Rider (Form # CH-26225-IR (03/09) AR)]	[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$.\$\$] [Incl.]
[Outpatient Diagnostic Services Benefit Rider (Form # CH-26226-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	[[Copayment][Facility Fee]	[\$\$\$\$.\$\$] [Incl.]
		[Maximum Benefit Amount (per Person, per Day): [\$500] [\$750] [\$1,000] [\$1,250] [\$1,500]]	
		[Maximum Benefit Amount (per Person, per Calendar Year): [\$2,500] [\$3,000] [\$5,000] [\$7,500]]	
[Covered Services Extension Rider (Form # CH-26228-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$.\$\$] [Incl.]
[Rate Guarantee Rider (Form # CH-26205-IR (08/08))]	[John Doe] [Jane Doe] [Baby Doe]	Guarantee Level: [24] [36] months	[\$\$\$.\$\$] [Incl.]
[Pregnancy/Childbirth Benefit Rider (Form # [CH-26213-IR (03/09) AR])]	[John Doe] [Jane Doe] [Baby Doe]	Maximum Benefit Amount (per pregnancy/childbirth): [\$1,000] [\$2,000] [\$3,000] [\$4,000] [\$6,000]	[\$\$\$\$.\$\$] [Incl.]
[Prescription Drug Expense Rider (Form # [(CH-26214-IR (03/09) AR)]]	[John Doe] [Jane Doe] [Baby Doe]	Maximum Benefit (per person, Calendar Year): [\$1,500][\$2,000] [\$5,000]	[\$\$\$\$.\$\$] [Incl.]
		Generic / Brand Drug Deductible (per Person, per Calendar Year): [[\$0 / \$50] [\$0 / \$250]]	
		Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply	
		discount: [25%][50%] Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$15] copayment	



Generic Non-Preferred Drugs, [90] day supply:
[100%] less [\$45] copayment
Brand Preferred Drugs, [90] day supply
discount: [50%]
Brand Non-Preferred Drugs, [90] day supply

discount: [25%]

[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]] [John Doe] [Jane Doe] [Baby Doe] Maximum Benefit (per Person, per Calendar Year): [\$500] [\$1,000] [\$1,500]

Calendar Year): [Incl.] 00] [\$1,500]

[\$\$\$.\$\$]

[\$\$\$\$.\$\$]

[Incl.]

[Date: [MM/DD/YY]]

Deductible

(per Person, per Calendar Year): [\$50] [\$75] [\$100] [\$150] [\$250]

Retail:

Generic Preferred Drugs, [30] day supply: [100%] less [\$5] [\$10] [\$15] copayment
Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$20] [\$25] [\$30] copayment
Brand Name Drugs, [30] day supply discount: [25%]

Mail-Order:

Generic Preferred Drugs, [90] day supply: [100%] less [\$10] [\$20] [\$30] copayment
Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$40] [\$50] [\$60] copayment
Brand Name Drugs, [90] day supply discount: [25%]

The following Certificates/Policies are underwritten by The MEGA Life and Health Insurance Company:

[MEGA Vision Plan (Vision Insurance Policy) (Form # [(26023-IP (5/07) AR)]) (VSIN)] [John Doe] [Jane Doe] [Baby Doe]

NETWORK: Deductible: [\$0]

Corrective Spectacle Lenses: [100%]
Corrective Contact Lenses (Non-Disposable or

Disposable): [\$40]
Corrective Contact Lenses (Therapeutic):

[100%]
Frames: [Not Covered]

Frames: [Not Covered]
Contact Lens Fitting: [Not Covered]
Follow-Up Visits: [Not Covered]

NON-NETWORK:
Deductible: [\$0]
Comprehensive Eye Exam: [\$30]
Corrective Spectacle Lenses: [75%]

Corrective Contact Lenses (Non-Disposable or

Disposable): [\$30]

Corrective Contact Lenses (Therapeutic): [75%]

Frames: [Not Covered]



		Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered]	
[MEGA Bronze (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLB)]	[John Doe] [Jane Doe] [Baby Doe]	[BRONZE (Option A-Diagnostic & Preventive): Deductible: [\$0]]	[\$\$\$.\$\$] [Incl.]
[MEGA Silver (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLS)]		[SILVER (Option B-Premiere): Deductible (per person, per year): [\$100] Benefit Maximum (per person, per year): [\$1000]]	
[MEGA Gold (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLG)]		[GOLD (Option C-Deluxe): Deductible (per person, per lifetime): [\$100] Benefit Maximum (per person, per year): [\$1200]	
		Orthodontics Benefit Maximum (per person, per month): [\$50] Orthodontics Benefit Maximum (per person, per lifetime): [\$1200]]	
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [\$10,000] [\$20,000] [\$30,000] [\$40,000] [\$50,000]	[\$\$\$\$.\$\$] [Incl.]
[Income Protection (Accident- Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [\$1000] [\$1500] [\$2000]	[\$\$\$\$.\$\$] [Incl.]
		Elimination Period (per disabled person): [14] [30] days	
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [\$1000] [\$1500] [\$2000]	[\$\$\$\$.\$\$] [Incl.]
(D3GF)]		[Blue Collar: Yes]	
		[White Collar: Yes]	
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[\$\$\$.\$\$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (Cl01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [\$10,000] [\$15,000] [\$20,000] [\$30,000] [\$40,000] [\$50,000] [\$60,000]	[\$\$\$\$.\$\$] [Incl.]



[MEGA Accident Advantage	[John Doe]	Accidental Injury Benefit Amount, per person,	[\$\$\$\$.\$\$]
(Accidental Injury Only Insurance	[Jane Doe]	per year:	[Incl.]
Certificate) (Form # [26038-C]) (ASLG)]	[Baby Doe]	[\$5000] [\$10,000] [\$15,000] [\$25,000]	
[Accident Expense Insurance	[John Doe]	Deductible, per person, per occurrence:	[\$\$\$\$.\$\$]
Plan (Accident Catastrophic	[Jane Doe]	[\$0] [\$600] [\$1,200] [\$2,400]	[Incl.]
Expense Plan Certificate of	[Baby Doe]		
Insurance) (Form # [25314]) (IA08)		Maximum Benefit, per person, per occurrence: [\$6,000] [\$12,000] [\$24,000]	
J		[\$0,000] [\$12,000] [\$24,000]	
		Coinsurance:	
		[100%] [80%] [50%]	
[Accident Expense Benefit Rider	[John Doe]	Deductible, per injury:	[\$\$\$\$.\$\$]
(Form # [25096])]	[Jane Doe]	[\$0] [\$100]	[Incl.]
	[Baby Doe]		
		Maximum Benefit, per injury	
		[\$600] [\$1,200]	
[Direct Benefit (Hospital	[John Doe]	Daily Benefit Amount (per person):	[\$\$\$\$.\$\$]
Confinement Indemnity	[Jane Doe]	[\$100] [\$200] [\$250] [\$300] [\$400]	[Incl.]
Certificate) (Form # [25874-C])	[Baby Doe]	[\$500] [\$1,000] [\$1,500]	
(DB01)]			
[023-Private Health Care Systems			[\$\$\$\$.\$\$]
(PHCS)]			[Incl.]
[074-Texas True Choice]			
[075-HealthSmart]			
[Certificate][Policy] Fee			[\$\$\$.\$\$]
			[Incl.]
		Total Estimated Recurring Payment:	[\$\$\$\$.00]
		Total Initial Payment:	[\$\$\$\$.00]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.



{The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited

ANY Physician/Specialist/Urgent Care Center/Hospital?

er/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited

ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]

Physician/Specialist Name: [Baby Doctor, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State]

[My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited

ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY] Reason(s)? [reason]

Result(s)? [results]

Recommendation(s)? [recommendations]



[John Doe] Beneficiary Information Details

First Name: [Jane]

BENEFICIARY INFORMATION

BENEFICIARY 1

STATEMENT OF VARIABILITY

{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.}

Middle Initial: [A]

Last Name			Suffi		
Beneficiary Relationship			Percentag	e: [XXX%]	
Othe					
Cit	y : [Fabulous]				
State					
Zij		1			
	p. [120 4 0-80/0]	j			
BENEFICIARY 2	<i>r</i> p : -				
First Name			Middle Initia		
Last Name	e: [Doe]		Suffi	x:	
Beneficiary Relationship			Percentag	e: [XXX%]	
Othe				·1	
Cit					
State		1			
Zij	p : [12345-9876]				
PRIOR COVERAGE					
{The following question is No	OT applicable for	the "MFGA Dental Plan	ı" (Dental İnsuranca Police	v. form 26000_IE	? (1/08)) and/or the
	(visiori insurand	o o munuy, luttii 20023-II	P (5/07) AR) only (it is app	mcavie ior all oth	ισι <u>μιατιδ</u> }
MEDICARE/MEDICAID				~ • •	
Is any Applicant eligible for	or currently cov	vered under Medicare	or Medicaid? • Yes	O No	
ĺ	, , , , , , , , , , , , , , , , , , ,				
[If "Yes", who)?	Reason			
		Financial] [Medical]			
		Financial] [Medical]			
O [E	Baby Doe] [F	Financial] [Medical]			
CURRENT HEALTH INSURA					
During the past two years,	has any person	n to be insured had in	nsurance declined, post	tponed, had a v	waiver applied. or
charged additional premiur					
S god additional promital		, Jvaidi ilioulullot	- 1au Jaon modiance		
If "Voo" whe?		Data	Doccor.	Mana	o of Company
If "Yes", who?] a a l	Date	Reason		e of Company
[John [-	[12/2000]	[XYZ Reason]		BC Insurance]
[Jane [Joe]	[05/2000]	[LMNOP Reason]	[DE	EF Insurance]
			-	-	
Does any Applicant curre	ntly have health	h insurance or has a	ny Applicant had healt	h insurance w	ithin the nast 12
months? O Yes O No	. J Health	or mas a	J HAM HEAR		puot 12
	aon in force will t	n the next so days a	Voc O Not right-	of concell-4:-	[[]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]
lıı resi, nas coverage b	een in force withir	ii iiie past bu days? O	Yes O No] [If "No", date	or cancellation:	[[[۲ ۲ ۲ ۲ ۱۷۱۱
			_		_
If "Yes", who? Groເ	ıp or Individual	Name of Company	Certificate/Policy	Type of	Date of Issue
· · · · · · · · · · · · · · · · · · ·	Coverage?	. ,	Number	Coverage	
[Jane Doe]	[Group]	[HIJ Insurance]		Accident-Only]	[05/2007]
L fogue Doel	[Oroup]	ני ווט וווסטומווטלן	[ADO 12040] [F	woodent-Only]	[03/200/]
F (15 11) / 11)	-141-		16		· · · · · · · ·
[{If "Yes"} Will existing hea	aith coverage be				
If "Yes", who?		On Issue	?	Date of Can	
[Jane Doe]		[Yes]		[10/20	
		[. 00]		[10.20	=
(/AD OTAT) 01/240 05000	- A DD (00/00) 4 =)-t [MAA/DD 2067
(VAR STMT) CH/MG-25098-	earr (03/09) AR	16		[<u>[</u>	Date: [MM/DD/YY]]



CURRENT LIFE INSURANCE	
Does any Applicant currently have life insurance or annuities? • Yes • No	
[If "Yes", who?	
Will the insurance applied for replace or otherwise reduce in value any life in O Yes O No	surance or annuities now in force?
[If "Yes", details: [details]	
Are you considering discontinuing making premium payments, surrendering, terminating your existing policy/certificate or contract? • Yes • No	forfeiting, assigning to the insurer, or otherwise
Are you considering using funds from your existing policies/certificates or policy/certificate or contract? O Yes O No	contracts to pay premiums due on the new
[If you answered "Yes" to either of the above questions, list each existing pol replacing (include the name of the insurer, the insured or annuitant, and the pand whether each policy/certificate or contract will be replaced or used as a so	policy/certificate or contract number if available)
INSURED OR ANNUITANT INSURER NAME CONTRA	- () -
[John Doe] [ABC Insurance] [POL12 [{If "Replaced (R)"} The existing policy/certificate or contract is being repl	23456] R
{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) of	
[MEDICAL QUESTIONS Have you or any Applicant EVER had symptoms, been diagnosed, receiv 1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? [If "Yes", is it professionally or for recreation?	ved medical advice or been treated for: O Yes O No O Professionally O Recreationally]
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
2. Heart or Cardiovascular Conditions/Disorders including but not limited to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
3. Endocrine Disorders including but not limited to – Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity?	O Yes O No



Select all Applicants this question applies to: 4. Blood Disorders including but not limited to - Blood or spleen disorder,	O [John Doe] O [Jane Doe] O [Baby Doe] O Yes O No
including anemia, leukemia, high cholesterol, or hyperlipidemia?	
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
5. Gynecological Disorders including but not limited to – male or female reproductive organ disorder or disease, including breast disorder or augmentation?	O Yes O No
· ·	
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
6. Cancer / Tumor or any benign or malignant growths, including but not limited to - Cancer, cyst, tumor, or neoplasm?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
7. Respiratory Disorders including but not limited to - Respiratory disorder,	
including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
8. Urinary Tract Disorders including but not limited to - Kidney, bladder,	
urinary tract, stones, or prostate disorders?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
9. Digestive Tract Disorders including but not limited to – GERD (gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or	
pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
12. Skin Disorders including but not limited to - Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]



14. Complications of Pregnancy including but not limited to - Cesarean	
section?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
17. Connective Tissue Disorders including but not limited to - Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue	O Yes O No
disease?	J res J No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs?	O Yes O No
dae of arry liftiba:	3 163 3 110
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an	
AIDS-related test?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had any other medical or surgical advice, hospitalizations, treatment, operations, or testing?	O Yes O No
testing:	3 100 3 110
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s),	



in	cluding any which were not filled?	O Yes O No		
[If "Yes", what condition(s)	is the prescribed medication for?]	[conditions]		
Select all A		O [John Doe] O [Jane Doe] O [Baby Doe]		
22c. Recent Medical Treatment – Have you or have additional testing, lab work, surgical or m	edical treatment, or had such that	O Yes O No		
Select all A	applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]]		
{The following questions are only applicable it	FApplicant(s) chose the "Critical Care an Transplant Certificate) (Form#[2			
 23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? 24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ, 				
Coronary aftery by-pass surger	y, coronary angioplasty or Alzheimer	disease? O Yes O No		
{The following section/questions will only be ask	red for the Applicants who selected " QUESTIONS" section above.}	Yes" to any of the questions in the "MEDICAL		
[ADDITIONAL HEALTH INFORMATION [secti				
[Based on previous answers, additional informati Applicant. Note: All of the information you provi	on is required. Please complete the			
Health Information For: [John Doe]				
[1] HAZARDOUS ACTIVITIES OR SPORTS {C in any hazardous sport or activity"} Select all conditions that apply:	Only asked if Applicant chose "Yes" to	o MEDICAL QUESTION #1: "Do you engage		
O Hot Air Ballooning	○ Fire Fighting	→ Flying for Hunting		
 Explosive Transportation 	○ Stunt Flying	O Crop Dusting		
Ultra LightsOther Aviation Related Activities	 Experimental Aircraft Flying Flight Testing	Helicopter / Rotorcraft FlyingOther Sports Activities		
[2] HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #2: "Heart attack, stroke, myocardial infarction"} Select all conditions that apply:				
O Heart Attack	O Stroke	 Myocardial Infarction 		
O Hypertension	O Angina Pectoris	O Transient Ischemia Attack (TIA)		
Coronary Artery DiseaseHeart-related Arteriogram	Any Form of Heart SurgeryAngioplasty	Coronary Artery SurgeryPacemaker		
O Disease or Disorder of the Heart	O Disease or Disorder of the Circu			
[3] ENDOCRINE DISORDERS {Only asked if A goiter"}		•		



Select all conditions that appl O Diabetes O Obesity	y: O Hypoglycemia	O Goiter	O Thyroid Disorder
[4] BLOOD DISORDERS (Only Select all conditions that appl	asked if Applicant chose "Yes" to	o MEDICAL QUESTION #4: "Blo	od or spleen disorder"}
O Spleen Disorder	O Anemia	O Leukemia	O Other Blood Disorder(s)
[5] GYNECOLOGICAL DISORD organ disorder"} Select all conditions that appl O Breast Disorder	DERS {Only asked if Applicant ch y: O Reproductive Organ Disorder		ON #5: "Breast or reproductive
[6] CANCER / TUMOR{Only ass	ked if Applicant chose "Yes" to M y :	IEDICAL QUESTION #6: "Cance	r, cyst, tumor, or neoplasm"}
O Cancer	O Cyst	O Tumor	O Neoplasm
[7] RESPIRATORY DISORDER including asthma'} Select all conditions that appl O Asthma O Emphysema	S {Only asked if Applicant chose y: O Bronchitis O Lung Disease	"Yes" to MEDICAL QUESTION COPD (Chronic Obstructive For Breathing Problems	
O Other Respiratory Disorder(s)			
[8] URINARY TRACT DISORDE urinary tract"} Select all conditions that appl O Kidney Disorder O Other Urinary Tract Disorder(O Urinary Bladder Disorder	se "Yes" to MEDICAL QUESTIO	N #8: "Kidney, urinary bladder, O Prostate Disorders
[9] DIGESTIVE TRACT DISORI gallbladder"} Select all conditions that appl	DERS {Only asked if Applicant cl	nose "Yes" to MEDICAL QUESTI	ON #9: "Stomach, intestines,
O Stomach Disorder	O Intestines Disorder	O Gallbladder Disorders	O Liver Disorder
Pancreas DisorderCirrhosis	O Ulcer O Enteritis	O Colitis O Hepatitis	O Crohn's Disease O Pancreatitis
	y asked if Applicant chose "Yes"	·	
O Hernia	O Hemorrhoids	O Polyps	O Rectal Disorders
[11] EYE, EAR, NOSE AND TH ear, nose"} Select all conditions that appl	ROAT DISORDERS (Only asked	d if Applicant chose "Yes" to MEL	DICAL QUESTION #11: "Eye,
O Eye Disorder	y. O Ear Disorder	O Nose Disorder	O Throat Disorder
[12]SKIN DISORDERS (Only as Select all conditions that appl		MEDICAL QUESTION #12: "Skin	disorders, burns, lacerations"}
O Burns O Chronic Rashes	O Lacerations O Melanoma	O Dermatitis O Other Skin Disorder(s)	O Boils
[13] MUSKULOSKELETAL DIS or leg disorder"} Select all conditions that appl	ORDERS {Only asked if Applica	nt chose "Yes" to MEDICAL QUI	ESTION #13: "Back, spine, arm
O Back Disorder	O Spine Disorder	O Arm Disorder	O Leg Disorder



O Arthritis	O Gout		O Bursitis	O Neuritis	
[14] COMPLICATIONS OF PRI pregnancy and/or Cesarean sec Select all conditions that appl • Cesarean Section	ction"}			CAL QUESTION #14: "Complic	ations of
[15] BRAIN DISORDERS {Only fainting"}	asked if Applicant	chose "Yes" to	o MEDICAL QUESTION	#15: "Brain disorder, epilepsy,	
Select all conditions that appl O Epilepsy O Paralysis O Chronic Headaches	y: ○ Fainting Spells ○ Tremors ○ Other Brain Dis		O Dizziness O Palsy	SeizuresHead Injury	
[16] MENTAL AND NERVOUS nervous disorder, depression	"}	y asked if App	licant chose "Yes" to ME	DICAL QUESTION #16: "Ment	al or
Select all conditions that appl O Mental Disorders O Alcoholism	y: O Nervous Disord O Drug Addiction	lers	O Depression	O Anxiety	
[17] CONNECTIVE TISSUE DIS Hodgkin's Lymphoma"} Select all conditions that appl O Hodgkin's Lymphoma O Other Connective Tissue Dis-	l y: O Non-Hodgkin's	.,	nt chose "Yes" to MEDIO	CAL QUESTION #17: "Hodgkin Collagen Disease	's or Non-
[18] ABNORMAL TEST RESUI a cancer test"}	()	Applicant chos	se "Yes" to MEDICAL Q	JESTION #18: "Any abnormal ı	results of
Select all conditions that appl Abnormal Results from PAP Abnormal Results from CEA Abnormal Results from Ches	Šmear (Carcinoembryonic	Antigen)	Abnormal Results froAbnormal Results froAbnormal Results fro	m PSA (Prostate Specific Antig	jen)
[19] SYMPTOMS FROM OTHER MEDICAL CONDITIONS {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #19: "Abnormal bleeding, swollen or enlarged prostate"} Select all conditions that apply:					
O Abnormal Bleeding	O Swollen or Enla	arged Prostate	O Nigh	t Sweats	
[20] MUSCULAR DISORDERS disorder"}		licant chose "`	Yes" to MEDICAL QUES	TION #20: "Any neurological di	isease or
Select all conditions that appl O Neurological Disease/Disorde O Loss of Use of a Limb		Numbness of	f an Extremity	O Muscular Disease/Disorder	
[21] AIDS / HIV {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #21: "Have you or any Applicant ever been diagnosed or treated"} Select all conditions that apply: O AIDS (Acquired Immune Deficiency Syndrome) O AIDS-Related Complex					

O Tested Positive for HIV (Human Immunodeficiency Virus) or an AIDS-Related Test



Health Information For: [John Doe]

HAZARDOUS ACTIVITIES OR SPORTS

Condition Detail

STATEMENT OF VARIABILITY

{The following section/questions will be asked depending on which condition the Applicant chose in the "CONDITIONS" section above.}

[ADDITIONAL HEALTH INFORMATION [section two]

1. What is the aviation activity you participate in?

[Based on previous answers, additional information is required. Please complete the requested information for the indicated Applicant. Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.]

Condition: Other Aviation Related Activities (Only asked if Applicant chose "Other Aviation Activities" to

[activity]

ADDITIONAL HEALTH INFORMATION [section one] question #1}

2. What type(s) of pilot's license do you currently hold?	[pilot's license type(s)]	
3. Are you a student pilot or flying instructor?	O Yes O No	
{If "Yes"} [Provide details:	[details]]	
4. Describe the type of aircraft you normally pilot		
and/or navigate:	[description]	
5. How many TOTAL hours flown?	[total hours]	
6. How many hours flown in the past 12 months?	[hours]	
7. Do you have a flight instrument rating?	O Yes O No	
{ f "Yes"} [Provide details:	[details]]	
Condition Detail		
HAZARDOUS ACTIVITIES OR SPORTS		
Condition: Other Sports Activities (Only a	asked if Applicant chose "Other Spo	orts Activities" to ADDITIONAL
HEALTH INFORMATION [secti		
Please provide additional details	. [details]	
Date of last participation	: [MM/YYYY]	
Condition Detail		
HEART OR CARDIOVASCULAR CONDITIONS/DISO		
Coronary Artery Surgery; Heart Related Arteriogram; D		Disease or Disorder of the Circulatory
System in ADDITIONAL HEALTH INFORMATION [sec		
Condition: [Any Form of Heart Surgery]		
Disease or Disorder of the Ho	eart] [Disease or Disorder of the C	Sirculatory System]
1. Do you have or have you had a history of:		
	rolled Hypertension or Tachycardia	O Cardiomegaly (Enlarged Heart)
	r Heart Disease	O Carotid Artery Disease
	ıd's Disease	O Arteritis
O Other O Hemop	hilia	O Arteriovenous (AV) Malformation
O Rheumatic Fever with Cardiac Residuals O Conges	stive Heart Failure	Cardiomyopathy
{The following question is only applica	able if the Applicant selects "Other" :	from the list above ?
	gnosis]	nom the list above.}
condition?	griosisj	
3. Date condition diagnosed or discovered: [MN	1/YYYY]	
4. Is the condition still present?	∕es O No	
•	M/YYYY]	
i loade supply date of last occurrence.		
5. Have you ever been disabled or O Y nospitalized?	'es O No	
VAR STMT) CH/MG-25098-eAPP (03/09) AR	23	[Date: [MM/DD/YY]



Disability / Hospit	talization	Start Date		Stop Date			
[details] [details] [details]		[MM/DD/YYY [MM/DD/YYY [MM/DD/YYY	Y] Y]	[MM/DD/YYYY] [MM/DD/YYYY] [MM/DD/YYYY]]			
6. Was medication tak	en or prescribed? rovide additional details:	O Yes O No					
Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping			
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]			
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]			
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]]			
Treating Physician Physician or Facility Name Phone Number Address Line 1 Address Line 2 City State and Zip Date Seen 8. Is there any type medication)? O You Type Treating Physician Physician or Facility Name Phone Number Address Line 1 Address Line 2 City State and Zip Start Date Stop Date Fully Recovered Additional Details 9. Any type of testing Scan)?	y [Harris HEB] :: [123-456-7890] :: [123 Health Street] :: :: [City] :: [TX] [12345] :: [MM/YYYY] of treatment, surgery es O No {If "Yes"} [F :: [type of treatment, su :: {Applicant will have the y [Harris HEB] :: :: [123-456-7890] :: [123 Health Street] :: :: [City] :: [TX] [12345] :: [MM/YYYY] :: [MM/YYYY] :: [MM/YYYY] :: [MM/YYYY] :: [MM/YYYY] :: [details] performed (i.e. Lab wo	or physical there elease provide additingery or physical the ability to select from a	apy scheduled, i onal details: erapy] a drop-down list base	recommended or completed (besides			
Type of Te	provide additional details	: Date of Tes	et I	Results and/or further testing?			
[MRI]	.31	[MM/YYYY		[details]			
[EKG]		[MM/YYYY		[details]			
	1	[MM/YYYY] [details]					

Condition Detail

HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS (Only asked if Applicant chose Hypertension in ADDITIONAL



	STA	ATEMENT OF	VARIABILITY	
	ON [section one] question # [Hypertension]	! 3}		
1. Is the high blood p	ressure under control? [If "Yes", for how long?	○ Yes ○ No [length of time]]		
	istory of heart or circulate 'Yes"} [Details: [details]]	ory problems incl	uding stroke, hea	art attack, or blocked arteries?
3. Last blood pressur [xxx /xxx] [MM/DD/ [xxx /xxx] [MM/DD/ [xxx /xxx] [MM/DD/	YY];	f known):		
4. Date condition dia	gnosed or discovered:	[MM/YYYY]		
5. Is the condition sti Please supply date		O Yes O No [MM/YYYY]		
6. Have you ever bee hospitalized? //f "Yes"} [Please	n disabled or provide additional details:	O Yes O No		
Disability / Hosp		Start Date		Stop Date
[details [details [details]	[MM/DD/YYY [MM/DD/YYY [MM/DD/YYY	Y] Y]	[MM/DD/YYYY] [MM/DD/YYYY] [MM/DD/YYYY]]
7. Was medication ta {If "Yes"} Please	ken or prescribed? provide additional details:	O Yes O No		
Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]]
Treating Physicia Physician or Facil Nam Phone Numbe Address Line Address Line Cit	ity [Harris HEB] e: er: [123-456-7890] 1: [123 Health Street]			s) (most current first). ed on previously entered physician info}
9. Is there any type medication)? O Y Typ Treating Physicia Physician or Facil Nam Phone Number	e of treatment, surgery of Yes O No {If "Yes"} [Ple e: [type of treatment, surger: {Applicant will have the aity [Harris HEB]	ease provide additingery or physical the	onal details: erapy]	recommended or completed (besides

City: [City]

Address Line 2:



State and Zi Start Dat Stop Dat Fully Recovered Additional Detail	e: [MM/YYYY] e: [MM/YYYY] d? O Yes O No					
10. Any type of testin Scan)?	g performed (i.e	e. Lab work, MRI, EKG, Ech	o, O Yes	O No		
{If "Yes"} [Please	provide addition					
Type of T	est	Date of Tes		Results and/or further testing?		
[MRI]		[MM/YYYY		[details]		
[EKG]		[MM/YYYY	-	[details]		
[Lab wor	k]	[MM/YYYY	']	[details]]		
11. Have you	made a full orecovery?	Yes O No				
ADDITIONAL HEALTH	H INFORMATION	d if Applicant chose Diabete I [section one] question #3} poglycemia] [Goiter] [Thy		Goiter; Thyroid Disorder; or Obesity in Obesity]		
1. Do you have or have						
O Glucose Intolerance)	Acromegaly		O Myxedema		
Hyperglycemia		Addison's Disease		Juvenile Hypothyroidism		
O Pituitary Tumor		O Cushing's Disease	or Syndrome	 Adrenal Gland Disorder 		
Other		O Cretinism				
{The foldone of the f	agnosis of your	s only applicable if the Applic condition? yroidism O Hypoglycemia	cant selects "Other	r" from the question above.} • Thyroid Nodule		
O Other Condition {If "Other Condition"} Details:		, , , , , , , , , , , , , , , , , , ,		·		
3. Date condition diag	gnosed or disco	overed: [MM/YYYY]				
4. Is the condition sti	Il present?	O Yes O No				
Please supply date	of last occurrenc	e: [MM/YYYY]				
5. Have you ever bee hospitalized?		O Yes O No				
{If "Yes"} [Please				04 D.4		
Disability / Hosp		Start Date		Stop Date		
[details	•	[MM/DD/YY		[MM/DD/YYYY]		
[details] [MM/DD/YYYY] [MM/DD/YYYY]						
[details]		[MM/DD/YY	[]	[MM/DD/YYYY]]		
6. Was medication taken or prescribed? • Yes • No {If "Yes"} [Please provide additional details:						
Medication	Dosage/Fred		Stop Date	Dr. advised/aware of stopping		
[medication]	[15mg twice p		[MM/YY]	[details]		
[medication]	[15mg twice p		[MM/YY]	[details]		
[medication]	[15mg twice p	per day] [MM/YY]	[MM/YY]	[details]]		



	STATEMENT OF VAR	ABILITI				
Treating Physician: {Ap	cians or facilities who treated you for the oplicant will have the ability to select from a drop-carris HEB]	condition(s) (most current first). down list based on previously entered physician info}				
Phone Number: [12 Address Line 1: [12 Address Line 2:	[123-456-7890] [123 Health Street]					
City: [Cit State and Zip: [TX Date Seen: [MN						
medication)? O Yes O Type: [type: [type: Treating Physician: {Ap Physician or Facility Name: Phone Number: [12 Address Line 1: [12 Address Line 2: City: [City: State and Zip: [TX Start Date: [MN Stop Date: [MN Fully Recovered?]	No {If "Yes"} [Please provide additional of pe of treatment, surgery or physical therapy] oplicant will have the ability to select from a drop-carris HEB] 23-456-7890] 23 Health Street]					
O. Any type of testing perfor Scan)? {If "Yes"} [Please provide	rmed (i.e. Lab work, MRI, EKG, Echo, e additional details:	O Yes O No				
Type of Test	Date of Test	Results and/or further testing?				
[MRI]	[MM/YYYY]	[details]				
[EKG]	[MM/YYYY]	[details]				
[Lab work]						
0. Have you made a full rec	covery? O Yes O No					
Condition Detail		_				
BLOOD DISORDERS (Only a HEALTH INFORMATION [sec		nemia; or Other Blood Disorder(s) in ADDITIONAL rder(s)]				

Description: [description] Hospitalization required? • Yes • No Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

> Treating Physician: [physician's name]

Physician or Facility Name: [name]

(VAR STMT) CH/MG-25098-eAPP (03/09) AR 27 [Date: [MM/DD/YY]]



Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

GYNECOLOGICAL DISORDERS {Only asked if Applicant chose Breast Disorder or Reproductive Organ Disorder in ADDITIONAL HEALTH INFORMATION [section one] question #5}

Condition: [Breast Disorder] [Reproductive Organ Disorder]

1	Do you	have or	have	VOII	had a	a history	of:
		Have OI	Have	vou	Hau (a iliətdi v	vı.

O Endometriosis O Cancer O Abnormal PAP Smears/Dysplasia O Polycystic Ovarian

Disease/Syndrome

O HPV (Human Papillomavirus) O Other

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your [diagnosis]

condition?

{The following question is only applicable if the Applicant selects "Abnormal PAP smears/Dysplasia" from the list above.}

3. Please provide additional details for Abnormal PAP smears/Dysplasia:

Class of PAP smear, number of abnormal PAPs and dates.

[details]

Number and date of normal PAP smears (since last abnormal PAP)

[details]

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? O Yes O No Please supply date of last occurrence: [MM/YYYY]

Have you ever been disabled or O Yes O No

6. Have you ever been disabled or hospitalized?

{If "Yes"} | Please provide additional details:

[II Tee] The case provide additional details:							
Disability / Hospitalization	Start Date	Stop Date					
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]					
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]					
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]]					

O Yes O No

7. Was medication taken or prescribed?

{ If "Yes"} I Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]]

Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}



Physician or Facility Name:	[Harris HEB]					
	[123-456-7890]					
	[123 Health Street]					
Address Line 2:	[120 Flediti Otreet]					
City:	[Citv]					
State and Zip:						
	,					
9 is there any type of	treatment surgery	or physical therapy scheduled,	rocommon	uded or completed (h	aeidae	
		ease provide additional details:	, recommen	ided of completed (b	csides	
•	, , -	gery or physical therapy]				
Treating Physician:						
Physician or Facility	[Harris HEB]	•	•			
Name:						
Phone Number:	[123-456-7890]					
Address Line 1:	[123 Health Street]					
Address Line 2:						
City:						
State and Zip:						
Start Date:						
Stop Date:						
•	O Yes O No					
Additional Details:	[details]					
10. Any type of testing po	erformed (i.e. Lab wor	k, MRI, EKG, Echo. O Yes	O No			
Scan)?	•	, , , ,				
{lf "Yes"} [Please pro	vide additional details:					
Type of Test		Date of Test	Resul	ts and/or further testin	ıg?	
[MRI]		[MM/YYYY]		[details]		
[EKG]		[MM/YYYY]		[details]		
[Lab work]		[MM/YYYY]		[details]]		
11. Have you made a full	recovery? • Yes) No				
Condition Detail						
		e Cancer; Cyst; Tumor; or Neoplas	sm in ADDITi	IONAL HEALTH		
INFORMATION [section of	2 ,					
Condition: [Ca	ancer] [Cyst] [Tumor	[Neoplasm]				
1. Do you have or have y	ou had a history of:					
O Cancer or Malignant Me		Metastasis		O Leukemia		
O Any Chemotherapy or F		O Hodgkin's Disea	SA.	O Bone Cancer		
O Recurrent Occurrences		O Lymphoma	.30	O Sarcoma		
O Brain Cancer	or Garicer	O Non-Hodgkin's L	vmnhoma	J Garcoma		
O Other		3 Non Houghins E	-ymphoma			
		pplicable if the Applicant selects "C	Other" from th	ne list above.}		
2. What is/was the diagno	osis of your	[diagnosis]				
condition?						
3. Date condition diagno	sed or discovered:	[MM/YYYY]				
4. Is the condition still pr	asant?	O Yes O No				
		[MM/YYYY]				
Please supply date of last occurrence:		[



5. Have you ever bee	n disabled or		O Yes O No		
hospitalized?					
{If "Yes"} [Please		l details:	Otant Data		Oton Data
Disability / Hosp			Start Date		Stop Date
[details [details			[MM/DD/YYY [MM/DD/YYY		[MM/DD/YYYY] [MM/DD/YYYY]
[details	•		[MM/DD/YYY		[MM/DD/YYYY]]
[details	l		וווישטייייוויין	1]	
6. Was medication ta {\(\text{If "Yes"} \) \[\text{Please} \]			O Yes O No		
Medication	Dosage/Fred	quency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p	per day]	[MM/YY]	[MM/YY]	[details]]
Treating Physicia Physician or Facili Nam Phone Numbe Address Line Address Line Cit State and Zi Date See 8. Is there any type medication)? O	n: {Applicant will ty [Harris HEB] e: er: [123-456-78: 1: [123 Health: 2: ty: [City] p: [TX] [12345] n: [MM/YYYY] e of treatment, Yes O No {If "	90] Street] surgery (Yes"} [Ple	or physical therease provide additi	apy scheduled, onal details:	recommended or completed (besides
Fully Recovered Additional Detail	n: {Applicant will ty [Harris HEB] e: er: [123-456-78] 1: [123 Health is 2: ey: [City] p: [TX] [12345] e: [MM/YYYY] e: [MM/YYYY] d? O Yes O N s: [details]	90] Street]		drop-down list base	ed on previously entered physician info}
9. Any type of testing Scan)? { f "Yes"} [Please			, MRI, EKG, Echo	o, O Yes	O No
Type of T			Date of Tes	st	Results and/or further testing?
[MRI]			[MM/YYYY	4	[details]
[EKG]			[MM/YYYY	•	[details]
[Lab wor	·k]		[MM/YYYY		[details]]
10. Have you made a	full recovery?	O Yes	O No		



Respiratory Disorder(: Condition:							spiratory Disorder(s)]	ı
1. Do you have or haO Lung TransplantO AsthmaO Other	a O Active Tuberculosis			Current Tumor or Neoplasm of the LungSarcoidosis within 5 years				
{The 2. What is/was the dicondition?	following questio	n is only a _l	<i>pplicable if</i> [diagnosi		olicant selects "Ot	her" from the	e list above.}	
{The	following question	is only ap	policable if	the App	licant selects "Ast	hma" from th	e list above.}	
3. Please provide ad					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
a. Are you currently us c. Are you currently us	sing oral steroids?	O Ye	s O No s O No		mild or seasonal? e you used a ster	oid inhalor	O Yes O No	
inhaler?	sing a steroid	9 16	5 J NO		is no longer requi		O Yes O No	
4. Date condition dia	gnosed or disco	vered:	[MM/YYY	Y]				
5. Is the condition st Please supply date		e:	O Yes C [MM/YYY					
6. Have you ever been hospitalized? {\[\if \['Yes'' \] \] \[\] Please		details:	O Yes) No				
Disability / Hos		uctalis.	Sta	art Date			Stop Date	
[details				DD/YYY			[MM/DD/YYYY]	
[details	•			DD/YYYY]			[MM/DD/YYYY]	
[details	•			DD/YYY			[MM/DD/YYYY] j	
7. Was medication ta {If "Yes"} [Please			O Yes) No				
Medication	Dosage/Fred		Start D		Stop Date	Dr. adv	vised/aware of stoppi	าg
[medication]	[15mg twice p		[MM/Y		[MM/YY]		[details]	
[medication]	[15mg twice p		[MM/\	-	[MM/YY]		[details]	
[medication]	[15mg twice p	er day]	[MM/Y	/Y]	[MM/YY]		[details]]	
Physician or Faci Nam Phone Numb Address Line Address Line Ci State and Z	an: {Applicant will lity [Harris HEB] ne: er: [123-456-789 1: [123 Health 9	have the al 90]	tho treated bility to selec	d you fo	or the condition(s drop-down list base	s) (most cur ed on previous	rent first). sly entered physician info}	
medication)? O Typ Treating Physicia	Yes O No {If "\ be: [type of treat	/es"}[Ple ment, surg have the al	ase provid ery or phy	le addition	onal details: erapy]		led or completed (be	

Name:



Phone Number: [123-456-789	0]						
Address Line 1: [123 Health S	treet]						
Address Line 2:							
City: [City]	City: [City]						
State and Zip: [TX] [12345]							
Start Date: [MM/YYYY]							
Stop Date: [MM/YYYY]							
Fully Recovered? O Yes O No							
Additional Details: [details]							
10. Any type of testing performed (i.e.	lah work MRI F	KG Fcho O Y	res O No				
Scan)?	Las work, mai, L	10, 20110,					
{If "Yes"} [Please provide additional	l details:						
Type of Test		e of Test	Results and/or further testing?				
[MRI]		M/YYYY]	[details]				
[EKG]		W/YYYY]	[details]				
[Lab work]	-	W/YYYY]	[details]				
[Eds Work]	[141]	*# · · · · · · · · · · · · · · · · · · ·	[dotallo]]				
11. Have you made a full recovery?	O Yes O No						
Condition Detail							
			Urinary Bladder Disorder; Kidney Stones;				
			NFORMATION [section one] question #8}				
		er Disorder] [Kidney	Stones]				
[Prostate Disor	ders] [Other Urina	y Tract Disorder(s)]					
1. Do you have or have you had a hist	ony of:						
O Renal Failure		tic Kidney Disease	O Dialysis or Kidney Transplant				
Recipient	O i diyeya	lic Mariey Discase	Julysis of Ridney Transplant				
O Chronic Nephritis or Nephrotic Syndro	me O Chronic	Glomerulonephritis	○ Elevated PSA				
O Other	O Kidney		O BPH (Benign Prostate Hypertrophy)				
3 3 11 10 1	3 Idanoy	3101100	3 Bi ii (Boingii i iostate i iyportiopily)				
{The following question is only applicate	ble if the Applicant :	selects "Other"; "Kidne	ey Stones"; "Elevated PSA"; or "BPH" from				
		list above.}					
2. What is/was the diagnosis of your	[diagnos	is]					
condition?		-					
· · · · · · · · · · · · · · · ·							
		e Applicant selects "Ki	dney Stone" from the list above.}				
3. Please provide additional details fo	r Kidney Stones:						
Number of occurrences: [number]	0 W 0 M						
Was (were) stone(s) passed?	O Yes O No						
Are stones now believed to be present?	O Yes O No						
Details: [details]							
(The following question is	anly applicable if the	Annlicant salacts "El	avated PSA" from the list above ?				
4. Please provide additional details fo		: Applicant selects En	evated PSA" from the list above.}				
	i Elevateu PSA.						
Most Recent Results: [number]							
Date of Result: [MM/YYY]							
5. Date condition diagnosed or discov	vered: [MM/YY	YY]					
C to the condition still arresent?	O Vaa) No					
6. Is the condition still present?	O Yes						
Please supply date of last occurrence	: [MM/YY	ן ז ז					



7. Have you ever bee	n disabled or		O Yes O No			
hospitalized?						
{If "Yes"} [Please]		l details:	Otant Data		Otan Bata	
Disability / Hosp			Start Date		Stop Date	
[details] [details			[MM/DD/YYY [MM/DD/YYY		[MM/DD/YYYY] [MM/DD/YYYY]	
[details]			[MM/DD/YYY		[MM/DD/YYYY]]	
[uctano			וווישטייייוויין	1]		
8. Was medication tal {If "Yes"} [Please p			O Yes O No			
Medication	Dosage/Fred	quency	Start Date	Stop Date	Dr. advised/aware of stopping	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]]	
9. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} Physician or Facility Name: Phone Number: [123-456-7890] Address Line 1: [123 Health Street] Address Line 2: City: [City] State and Zip: [TX] [12345] Date Seen: [MM/YYYY] 10. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? O Yes O No {If "Yes"} [Please provide additional details: Type: [type of treatment, surgery or physical therapy] Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} Physician or Facility [Harris HEB]						
Nam Phone Numbe Address Line Address Line	er: [123-456-78 1: [123 Health 2:					
Cit State and Zi						
Start Dat						
	e: [MM/YYYY]					
Fully Recovered		0				
Additional Detail	s: [details]					
11. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Yes O No Scan)? {// "Yes"} [Please provide additional details:						
Type of T			Date of Tes	st	Results and/or further testing?	
[MRI]			[MM/YYYY		[details]	
[EKG]			[MM/YYYY		[details]	
[Lab wor	k]		[MM/YYYY]	[details]]	
12. Have you made a	full recovery?	O Yes) No			
12. Have you made a	Tull lecovery?	J 163 (J 11U			

Condition Detail

DIGESTIVE TRACT DISORDERS (Only asked if Applicant chose Stomach Disorder; Intestines Disorder; Gallbladder Disorder;



		317	A I E WIEN I OF	VARIABILIT			
INFORMATION [section	on one] question a [Stomach Diso	#9} rder] [Inte	estines Disorder]	[Gallbladder Dis	or Pancreatitis in ADDITIONAL HEALTH sorder] [Liver Disorder] Enteritis] [Hepatitis] [Pancreatitis]		
 Do you have or have you had a history of: Hepatitis other than Acute Type A Bleeding or Recurrent Ulcer within 5 years Any Weight Loss Surgery Liver abscess or enlargement within 1 year Other 			 Malabsorption Syndrome Recurrent Pancreatitis Unoperated Pancreatic Cyst or Tumor Ulcerative Colitis Controlled by Oral Steroids Pan Colitis 				
{The 2. What is/was the diacondition?		n is only a _l	pplicable if the App [diagnosis]	olicant selects "Ot	her" from the list above.}		
3. Date condition diag	gnosed or disco	vered:	[MM/YYYY]				
4. Is the condition still present? Please supply date of last occurrence:			O Yes O No [MM/YYYY]				
5. Have you ever bee hospitalized? {\[\text{If "Yes"} \text{ [Please } \]		details:	O Yes O No				
Disability / Hosp		uctans.	Start Date		Stop Date		
[details			[MM/DD/YYY		[MM/DD/YYYY]		
[details			[MM/DD/YYY		[MM/DD/YYYY]		
[details			[MM/DD/YYY	-	[MM/DD/YYYY]]		
6. Was medication ta {\lf "Yes"} [Please			O Yes O No				
Medication	Dosage/Freq	uency	Start Date	Stop Date	Dr. advised/aware of stopping		
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]		
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]		
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]]		
	n: {Applicant will ty [Harris HEB] e: er: [123-456-789 1: [123 Health 9 2: y: [City] p: [TX] [12345]	have the al 90]			s) (most current first). ed on previously entered physician info}		
medication)? O	Yes ○ No {If "Yee: [type of treating the streat of the st	′es″}【Ple ment, surg	ase provide addition	onal details: erapy]	recommended or completed (besides ed on previously entered physician info)		

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]



Address Line 2:

City: [City]

State and Zip: [TX] [12345] Start Date: [MM/YYYY] Stop Date: [MM/YYYY] Fully Recovered? • Yes • No Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, O Yes O No

Scan)?

(If "Yes") | Please provide additional details:

(iii rea) [i lease provide additional details.						
Type of Test	Date of Test	Results and/or further testing?				
[MRI]	[MM/YYYY]	[details]				
[EKG]	[MM/YYYY]	[details]				
[Lab work]	[MM/YYYY]	[details]]				

10. Have you made a full recovery? • Yes • No

Condition Detail

COLON DISORDERS (Only asked if Applicant chose Hernia; Hemorrhoids; Polyps; or Rectal Disorders in ADDITIONAL

HEALTH INFORMATION [section one] question #10}

Condition: [Hernia] [Hemorrhoids] [Polyps] [Rectal Disorders]

Description: [description] Hospitalization required? O Yes O No

Operation required? O Yes O No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate

physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

[Date: [MM/DD/YY]]

rescription Information

Frescription information			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

EYE, EAR, NOSE, THROAT DISORDERS (Only asked if Applicant chose "Eye Disorder"; "Ear Disorder"; "Nose Disorder"; or "Throat Disorder" in ADDITIONAL HEALTH INFORMATION [section one] question #11}

Condition: [Eye Disorder] [Ear Disorder] [Nose Disorder] [Throat Disorder]

Description: [description] **Hospitalization required?** • Yes • No



Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATIONDOSAGE / FREQUENCYSTART DATESTOP DATE[medication][50mg; once per day][MM/YYYY][MM/YYYY][medication][100mg; once per day][MM/YYYY][MM/YYYY]

Condition Detail

SKIN DISORDERS *{Only asked if Applicant chose "Burns"; "Lacerations"; "Dermatitis"; "Boils"; "Chronic Rashes"; "Melanoma"; or "Other Skin Disorder(s)" in ADDITIONAL HEALTH INFORMATION [section one] question #12}*

Condition: [Burns] [Lacerations] [Dermatitis] [Boils] [Chronic Rashes] [Melanoma] [Other Skin

Disorder(s)]

Description: [description] **Hospitalization required?** O Yes O No

Operation required? O Yes O No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate

physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]



MUSCULOSKELETAL Disorder; Arthritis; Gou Condition:	ıt; Bursitis; or Ne	uritis in ADDI7	TONAL HEALT	TH INFORMATIO		on #13}	
 Do you have or have you had a history of: Rheumatoid Arthritis Systemic Lupus Scoliosis greater than 30 degrees or with Rods Muscular Distrophy AS (Ankylosing Spondylitis Other 			 Severe or Disabling Degenerative Joint Disease Severe or Disabling Disc Disease Severe or Disabling Osteoporosis Arthritis requiring gold treatments or Methotrexate Chronic Pain Syndrome 				
{The following question is only applicable if the Applicant selects "Other" from the list above.} 2. What is/was the diagnosis of your [diagnosis] condition?							
3. What is the specific involved?	c area	Back:	O Upp	er	O Middle	O Lower	
mvorved ?		Other Location [details]	n: O Rigl	nt	O Left	Other	
4. Date condition diag	gnosed or disco	overed: [M	IM/YYYY]				
5. Is the condition still Please supply date			Yes O No IM/YYYY]				
6. Have you ever been hospitalized? {\[\if \['Yes'' \] \] Please \[\if \[''Yes'' \] \]			Yes O No				
Disability / Hosp			Start Date		Stop	Date	
[details]			[MM/DD/YYY	Y]	[MM/DE)/YYYY]	
[details]			[MM/DD/YYY	•	_)/YYYY]	
[details]			[MM/DD/YYY	Y]	[MM/DD/	YYYY]]	
7. Was medication tal {\lf "Yes"} [Please p			Yes O No				
Medication	Dosage/Fred	quency	Start Date	Stop Date	Dr. advised/aw	are of stopping	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]		ails]	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]		ails]	
[medication] 8. Please indicate the Treating Physician Physician or Facilit Name Phone Numbe Address Line Address Line City State and Zig Date Seen	n: {Applicant will ty [Harris HEB] e: rr: [123-456-78 1: [123 Health 2: y: [City] p: [TX] [12345] n: [MM/YYYY]	facilities who I have the ability 90] Street]	to select from a	drop-down list bas	ed on previously entered). I physician info}	
9. Is there any type medication)? O Y					recommended of C	ompieted (besides	



	ı ype:	Įtyp	oe o	t tre	eatme	ent, su	ırgery	or	pny	sıcaı	tnerapyj

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

Physician or Facility [Harris HEB]

Name:

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]

Address Line 2:

City: [City]

State and Zip: [TX] [12345] Start Date: [MM/YYYY] Stop Date: [MM/YYYY] Fully Recovered? • Yes • No Additional Details: [details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo,

O Yes O No

Scan)?

{If "Yes"} [Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details]]

11. Have you made a full recovery? • O Yes • No

Condition Detail

COMPLICATIONS OF PREGNANCY (Only asked if Applicant chose "Cesarean Section" or "Other Complications of Pregnancy" in ADDITIONAL HEALTH INFORMATION [section one] question #14}

Condition: [Cesarean Section] [Other Complications of Pregnancy]

Description: [description]

Hospitalization required? O Yes O No Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

> Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

> State: [TX] ZIP [12345]

> > Code:

Prescription Information

Frescription information			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]



BRAIN DISORDERS {Only asked if Applicant chose Epilepsy; Fainting Spells; Dizziness; Seizures; Paralysis; Tremors; Palsy; Head Injury; Chronic Headaches; or Other Brain Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #15}

Condition: [Brain Disorder] [Epilepsy] [Fainting Spells] [Dizziness] [Seizures] [Paralysis] [Tremors] [Palsy] [Head Injury] [Chronic Headaches] 1. Do you have or have you had a history of: O Brain Bleed (Cerebral Hemorrhage) O Narcolepsy O Cerebral Palsy O Stroke or Cerebrovascular Attack O Neuropathy O Brain Abscess within 5 years O Tourette's Syndrome ○ TIA (Transient Ischemic Attack) O Alzheimer's Disease O Pituitary Tumor O Congenital Brain Disorder O Hydrocephalus with Shunt/Stent O Malignant Brain Tumor O Parkinson Disease O Other {The following question is only applicable if the Applicant selects "Other" from the list above.} 2. What is/was the diagnosis of your [diagnosis] condition? 3. If seizure(s), type of seizure(s) [type of seizure] Frequency: [frequency] 4. Date condition diagnosed or discovered: [MM/YYYY] O Yes O No 5. Is the condition still present? Please supply date of last occurrence: [MM/YYYY] O Yes O No 6. Have you ever been disabled or hospitalized? {If "Yes"} | Please provide additional details: Disability / Hospitalization **Start Date Stop Date** [details] [MM/DD/YYYY] [MM/DD/YYYY] [details] [MM/DD/YYYY] [MM/DD/YYYY] [details] [MM/DD/YYYY] [MM/DD/YYYY]] 7. Was medication taken or prescribed? O Yes O No {If "Yes"} [Please provide additional details: Dosage/Frequency Start Date Dr. advised/aware of stopping Medication Stop Date [medication] [15mg twice per day] [MM/YY] [MM/YY] [details] [15mg twice per day] [medication] [MM/YY] [MM/YY] [details] [medication] [15mg twice per day] [MM/YY] [MM/YY] [details] 1

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

Physician or Facility [Harris HEB]

Name:

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]

Address Line 2:

City: [City]

State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? •• Yes •• No {If "Yes"} [Please provide additional details:

Type: [type of treatment, surgery or physical therapy]

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

Physician or Facility [Harris HEB]



Nam	ne:				
Phone Number		901			
Address Line	•				
Address Line	•	•			
	ty: [City]				
	ip: [TX] [12345]				
Start Dat	te: [MM/YYYY]				
Stop Dat	te: [MM/YYYY]				
Fully Recovered	d? O Yes O No)			
Additional Detai	ls: [details]				
10. Any type of testir Scan)?	ng performed (i.e	. Lab work, N	/IRI, EKG, Ech	o, O Yes	O No
{ <i>If "Yes"</i> } [Please	provide additiona	al details:			
Type of T			Date of Tes	st	Results and/or further testing?
[MRI]			[MM/YYYY		[details]
[EKG]			[MM/YYYY	•	[details]
[Lab wo			[MM/YYYY	•	[details]
•	-		-	-	· · · · · ·
11. Have you made a	a full recovery?	O Yes O No	0		
Condition Detail					
					ders; Nervous Disorders; Depression;
					ction one] question #16}
Condition:	[Mental Disorde	ers] [Nervou	s Disorders]	[Depression] [A	nxiety] [Alcoholism] [Drug Addiction]
1 Do you have or ha	vo vou had a hia	tory of:			
 Do you have or ha Alzheimer's Diseas 			erebral Palsy		O Psychosis or Psychotic Disorders
			erebrai Paisy hemical Imbala	2000	
O Anorexia or Bulimia			ysthymic Disor		O Nervous Breakdown within 5 years
Moderate or SevereAutism	Anxiety		lanic or Major [NeuropathySchizophrenia
				Stress Disorder	O Other
O Bipolar Disorder		J P	ost HauffiallC	011699 DISOLUEI	→ Oulei
{The	following question	n is only appli	cable if the Ap	plicant selects "O	ther" from the list above.}
2. What is/was the di			iagnosis]	,	- ,
condition?	J ,				
			11.10.00.00		
3. Date condition dia	gnosed or disco	vered: [N	IM/YYYY]		
A le the condition of	ill procent?	\sim	Voc. O No.		
4. Is the condition st	•		Yes O No IM/YYYY]		
Please supply date	or last occurrence	. . [Ⅳ	111/1111		
5. Have you ever bee	n disabled or	O	Yes O No		
hospitalized?		_			
{If "Yes"} [Please	provide additional	details:			
Disability / Hosp			Start Date	!	Stop Date
[details			[MM/DD/YYY		[MM/DD/YYYY]
[details			[MM/DD/YYY		[MM/DD/YYYY]
[details	ij		[MM/DD/YYY	Υj	[MM/DD/YYYY]]
•	-			-	
6. Was medication ta			Yes O No		
{If "Yes"} [Please					
Medication	Dosage/Freq		Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]
(VAR STMT) CH/MG-2	25098-eAPP (03/0)9) AR	40		[Date: [MM/DD/Y
•	,	•			



[medication]	15mg twice per day]	[MM/YY]	[MM/YY]	[details] 1		
7. Please indicate the phy	. , , , , ,	ho troated you f	or the condition(s	(most current first)		
				d on previously entered physician info}		
	[Harris HEB]	,	,	, p. 11. 11. 11. p. 3. 11. 13.		
Name:						
Phone Number:	[123-456-7890]					
Address Line 1:	[123 Health Street]					
Address Line 2:						
	[City]					
State and Zip:						
Date Seen:	[MM/YYYY]					
Bate Seef. [MM/YTYT] 8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)?						
Type of Test		Date of Tes	st	Results and/or further testing?		
[MRI]		[MM/YYYY	-	[details]		
[EKG]		[MM/YYYY		[details]		
[Lab work]		[MM/YYYY]	[details]]		
10. Have you made a fu	II recovery? O Yes	ON C				
ADDITIONAL HEALTH INF	SORDERS {Only asked FORMATION [section of bllagen Disease] [Con	ne] question #17}	-	e" or "Connective Tissue Disorder(s)" in		
	Description:	[description]				
Hosp	oitalization required?					
	Operation required?					
Treatment Information						
meannein miloimanon	Treatment:	[details]				
	Start Date:	[MM/DD/YYYY]		Stop Date: [MM/DD/YYYY]		
	Juli Dulo.			cop and [mmoon [1]]		
Enter the treating physician details.		ition below or s	select previously	entered physician name to populate		



Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

ABNORMAL TEST RESULTS (Only asked if Applicant chose "Abnormal Results from PAP Smear"; "Abnormal Results from Mammogram"; "Abnormal Results from CEA..."; "Abnormal Results from PSA..."; "Abnormal Results from Chest X-Ray"; or "Abnormal Results from Other Test" in ADDITIONAL HEALTH INFORMATION [section one] question #18}

Condition: [Abnormal Results from PAP Smear] [Abnormal Results from Mammogram]

[Abnormal Results from CEA (Carcinoembryonic Antigen)] [Abnormal Results from PSA (Prostate Specific Antigen)]

[Abnormal Results from Chest X-Ray] [Abnormal Results from Other Test]

Description: [description]

Hospitalization required? • Yes • No

Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

> Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

> State: [TX] ZIP [12345]

> > Code:

[Date: [MM/DD/YY]]

Prescription Information

i rocompacin illionilation			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

SYMPTOMS OF OTHER MEDICAL CONDITIONS (Only asked if Applicant chose "Abnormal Bleeding" or "Night Sweats" to ADDITIONAL HEALTH INFORMATION [section one] question #19}

Condition: [Abnormal Bleeding] [Night Sweats]

Description: [description]

Hospitalization required? • Yes • No



Operation required	O Yes O No						
Treatment Information							
Treatment Start Date		Stop Date: [MM/DD/YYYY]					
Enter the treating physician's information physician details.	nation below or select previous	sly entered physician name to populate					
Treating Physician Physician or Facility Name Phone Number Address Line 1 Address Line 2 City State	: [name] : [123-456-7890] : [123 Anywhere St.] : [Suite 100] : [My Town]	ZIP [12345] de:					
Prescription Information	DECLIENCY OTABLE	ATE					
MEDICATION DOSAGE / FI [medication] [50mg; onc							
[medication] [30mg; one							
URINARY TRACT DISORDERS {Only asked if INFORMATION [section one] question #19} Condition: Swollen or Enlarged Pr 1. Do you have or have you had a history of: O Renal Failure	Condition: Swollen or Enlarged Prostate 1. Do you have or have you had a history of:						
O Chronic Nephritis or Nephrotic Syndrome O Other	•	D Elevated PSA D BPH (Benign Prostate Hypertrophy)					
	the list above.}						
2. What is/was the diagnosis of your condition?	[diagnosis]						
{The following question is only applicable if the Applicant selects "Kidney Stone" from the list above.} 3. Please provide additional details for Kidney Stones: Number of occurrences: [number] Was (were) stone(s) passed?							
{The following question is only applicable if the Applicant selects "Elevated PSA" from the list above.} 4. Please provide additional details for Elevated PSA: Most Recent Results: [number] Date of Result: [MM/YYY]							
5. Date condition diagnosed or discovered:	[MM/YYYY]						
6. Is the condition still present? Please supply date of last occurrence:	O Yes O No [MM/YYYY]						



7. Have you ever been disabled or O Yes O No hospitalized?						
{If "Yes"} [Please p	orovide additional	details:				
Disability / Hospitalization			Start Date	1	Stop Date	
[details]			[MM/DD/YYY	Y]	[MM/DD/YYYY]	
[details]			[MM/DD/YYY	Y]	[MM/DD/YYYY]	
[details]			[MM/DD/YYY	Y]	[MM/DD/YYYY]]	
8. Was medication tal			O Yes O No			
Medication	Dosage/Freq	uency	Start Date	Stop Date	Dr. advised/aware of stopping	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]]	
9. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician:						
{If "Yes"} [Please		al details:				
Type of To	est		Date of Tes		Results and/or further testing?	
[MRI]		[MM/YYYY]		-	[details]	
[EKG]			[MM/YYYY	•	[details]	
[Lab wor	Kj		[MM/YYYY		[details]]	
12. Have you made a	full recovery?	O Yes) No			
,			-			
0 "" 5 ' "	Our difference of the control of the					

Condition Detail

MUSCULAR DISORDERS (Only asked if Applicant chose "Neurological Disease/Disorder"; "Numbness of an Extremity";



"Muscular Disease/Disorder"; or "Loss of Use of a Limb" in ADDITIONAL HEALTH INFORMATION [section one] question #20}

Condition: [Neurological Disease/Disorder] [Numbness of an Extremity] [Muscular Disease/Disorder]

[Loss of Use of a Limb]

Description: [description]

Hospitalization required? O Yes O No

Operation required? O Yes O No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

> Treating Physician: [physician's name]

Physician or Facility Name: [name]

> Phone Number: [123-456-7890] [123 Anywhere St.] Address Line 1:

[Suite 100] Address Line 2:

[My Town] City:

State: [TX] ZIP [12345]

Code:

Prescription Information

. ccc. puch mile manen			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

RECENT MEDICAL TREATMENT (Only asked if Applicant chose "Yes" to MEDICAL QUESTION #22: ("WITHIN THE LAST FIVE YEARS, have you...")}

Description: [description]

Hospitalization required? • Yes • No

Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [XT] ZIP [12345]

Code:

Prescription Information

MEDICATION DOSAGE / FREQUENCY START DATE STOP DATE [medication] [50mg; once per day] [MM/YYYY] [MM/YYYY]



[medication] [100mg; once per day] [MM/YYYY] [MM/YYYY]

Condition Detail

FAMILY HISTORY (Only asked if Applicant chose "Yes" to MEDICAL QUESTION #23: ("Have either of your parents, brothers, or sisters been diagnosed...")}

Condition: Family Record of Proposed Insured

FAMILY MEMBER	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
[Father]	[impairment]	[age]	[age] [n/a]
[Mother]			
[Brother]			
[Sister]			

Condition Detail

TRANSPLANT (Only asked if Applicant chose "Yes" to MEDICAL QUESTION #24 & 25: ("Have you or any Applicant ever received (or been diagnosed..." or " Have you or any Applicant ever consulted with or been treated by...")}

Condition: Transplant

Please provide additional details.

[details]

Additional Prescription Medications

Are there any additional prescription medications that you or any applicant are currently taking, or have been

prescribed which have not vet been filled? • Yes • No

	Applicant Medication		Dosage & Frequency	Condition	Start Date	Stop Date
I	[John Doe]	[Allegra]	[180 mg; twice per day]	[environmental allergies]	[12/2006]	[N/A]
	[Jane Doe]	[Astelin]	[2 sprays; twice per day]	[environmental allergies]	[07/2006]	[N/A]
	[Baby Doe]	[Zyrtec]	[1 tsp; once per day]	[environmental allergies]	[08/2006]	[03/2007]



PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT]

1st Payment: [\$\$\$.00]

Credit Card Type: [O VISA O MasterCard]

Name of Cardholder as it appears on the card: [John Doe]
Relationship of Payor to Primary Applicant: [self]
[Reason for Payor Being Different than Applicant: [reason]]

Type of Card: [O Credit O Debit]

Account Type: [Personal]

Credit Card Number: [5525-XXXX-XXXX-XX54]

Expiration Date: [01/10]

Cardholder's Billing Address Line 1: [address]

Cardholder's Billing Address Line 2:

City: [city]
State: [TX]

Zip: [zip code]

Cardholder's Phone Number: [phone number]

[EFT INITIAL PAYMENT]

1st Payment: [\$\$\$.00]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx0089]
Confirm Bank Routing Number: [xxxxx9485]
Confirm Bank Account Number: [xxxxx0089]

Check Number: [1000]
Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]

Primary Name on Bank Account: Title: [Mr.] Name: [John C. Doe]

Relationship of Payor to Primary Applicant: [O Self O Spouse O Guardian O Approved Family Member]

[Reason for Payor Being Different than Applicant: [reason]]
Same mailing address as Primary Applicant? O Yes O No

{If "No"} [Mailing Address: [address]
Apt or Suite Number: [number]

City: [My Town]

State: [TX] **ZIP Code**: [12345]]

[Date: [MM/DD/YY]]

Driver's License Number of Primary on Bank Account: [xxxxxx78] State: [TX]

NOTICE: PAYMENT AUTHORIZATION

Transaction Authorization: By typing in my driver's license or identification number above, I confirm that I am the owner of the account identified by the MICR numbers entered in the Internet check [above] and authorize this merchant and/or TeleCheck to convert my account information entered above into a paper draft drawn on, or an electronic debit to, my account for the amount of this transaction. [If you choose to use a different form of payment, please click Previous.]

For more information on TeleCheck's process and privacy policy, see {hyperlink} Internet Check FAQ and {hyperlink} TeleCheck Privacy Policy.



[ONGOING PAYMENTS]

Ongoing Payments: [● Checking Account Electronic Fund Transfer (EFT)

O Savings Account Electronic Fund Transfer (EFT)

O Bill Me]

Payment Mode: [Monthly O Quarterly O Annually]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx0089]
Confirm Bank Routing Number: [xxxxx9485]

Confirm Bank Account Number: [xxxxx9465]

Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]
Primary Name on Bank Account: [John C Doe]

Relationship of Payor to Primary Applicant: [relationship]
[Reason for Payor Being Different than Applicant: [reason]]

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE - [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE – [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

(VAR STMT) CH/MG-25098-eAPP (03/09) AR 48 [Date: [MM/DD/YY]]



FOR HOME OFFICE USE ONLY

Special Request(s): [office use only text] {only agent allowed to fill in text here}

[Association] Membership: [NASE Premiere] {system-generated} [Association] Membership Number: [0123456789] {system-generated} [Association Membership] Paid-to Date: [09/15/2008] {system-generated} [Association Membership] Effective Date: [06/15/2008] {system-generated}

Lead ID: [1234-ABC]

Market Type: [Association Group (I)]

ELECTRONIC SIGNATURE -	- [Bobby Greatagen	t]				
Producer ID: [123456 Do you have any knowledge any existing life insurance or	or reason to believe		d(s) is ir	ntending to replac	e or otherwise reduce in va	lue
By checking the box and en electronically sign this applica		w, I am indicating my ag	reemen	t with the indicat	ed statement and my intent	t to
	☐ I certify that each question on this application was asked by me of the Applicant(s), and I have accurately recorded all answers given by the Applicant(s).					
OR						
☐ I certify to the best of ron this application.	ny knowledge and be	lief the Applicant(s) has/	nave pe	rsonally recorded	I the answers to each quest	ion
Please type your name in the First Name: [Bobby]	e spaces below to ele MI: [i	, , , , , ,	cation. Name:	[Greatagent]	Suffix:	
Please re-type your name in First Name: [Bobby]	the spaces below to o	, ,	Name:	[Greatagent]	Suffix:	

END OF APPLICATION FOR INSURANCE