



APPLICATION SUPPLEMENT

 APPLICANT NAME (PRINT)

 APPLICANT SIGNATURE

 DATE

 AGENT NAME (PRINT)

 AGENT SIGNATURE

 DATE

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.
9.			DEP. 7						
10.			DEP. 8						
11.			DEP. 9						
12.			DEP. 10						
13.			DEP. 11						
14.			DEP. 12						

SUPPLEMENTAL HOSPITAL, MEDICAL AND SURGICAL EXPENSE INSURANCE

	Child 7 YES/NO	Child 8 YES/NO	Child 9 YES/NO	Child 10 YES/NO	Child 11 YES/NO	Child 12 YES/NO
1. Does each proposed Applicant have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list below:						
_____ Company	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____ Policy Number						
_____ Effective Date						
IF THE ANSWER TO QUESTIONS 2-7 IS "YES" THEN THAT APPLICANT IS NOT ELIGIBLE FOR SUPPLEMENTAL EXPENSE COVERAGE.						
2. During the past (3) months, except for minor illness of (1) week or less or pregnancy, has any illness or health related problem prohibited any proposed Applicant from working full time at his/her regular occupation or performing the normal activities of a person of the same age?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Within the past 2 years, has any Applicant been diagnosed with or received treatment by a physician, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SUPPLEMENTAL HOSPITAL, MEDICAL AND SURGICAL EXPENSE INSURANCE CONT.

	Child 7 YES/NO	Child 8 YES/NO	Child 9 YES/NO	Child 10 YES/NO	Child 11 YES/NO	Child 12 YES/NO
5. Within the past 2 years has any Applicant been diagnosed with, taken medication or received treatment by a physician for a heart attack, had a bypass or stent, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment by a physician for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
7. Within the past 4 years has any Applicant used illegal drugs, been diagnosed with or received any medical treatment by a physician, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
8. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

ACCIDENT EXPENSE INSURANCE

	Child 7 YES/NO	Child 8 YES/NO	Child 9 YES/NO	Child 10 YES/NO	Child 11 YES/NO	Child 12 YES/NO
IF AN ANSWER TO QUESTION 9 OR 10 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.						
9. Within the past 12 months has any Applicant engaged in or had intentions to engage in any hazardous sports or activities including motorcycle or automobile racing, parachuting, rodeo riding, mountain climbing or scuba diving to depths greater than 60 feet (18 meters)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
10. Within the past 3 years has any Applicant been under treatment for excessive drug or alcohol abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

CHILDREN'S DOCTOR NAME:		PHONE NUMBER			
ADDRESS	CITY	STATE		ZIP	

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dated at _____ on _____ 20____.

City, State & Zip Month & Day Year

Signature of Applicant #1 _____ Signature of Spouse: _____