Persona... General ... General ... Health H... Health H... Health H... Health H... Medicati... Chronic ... Summary

- Risk Assessment for: ____________________

Smoker Details

Have you used any type of products containing tobacco or Nicotine in the last 5 years *

Yes No

Personal Details

Have you gained or lost weight during the last 12 months?

Yes No

Family History

Is your Father still living? Yes No Age:_____ Reason: __________________

Is your Mother still living? Yes No Age_____ Reason:___________________

Occupation

Remove

Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation?

Yes No

Initial:______

Persona... | General ... | General ... | Health H... | Health H... | Health H... | Health H... | Medicati... | Chronic ... | Summary

- Risk Assessment

Other Applications

Within the past 12 months have you applied for or do you have any applications pending for life or disability insurance?

Yes No

General Information - Proposed Insured

Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy?

Yes No

Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party, such as (but not limited to) a life settlement company or investor group?

Yes No

Initial:_____

Persona... | General ... | General ... | Health H... | Health H... | Health H... | Health H... | Medicati... | Chronic ... | Summary

- RiskAssessment

General Information - Proposed Insured (cont.)

During the last 5 years have you plead guilty to or been convicted of any moving vehicle violations or DUI or have you had a suspended license?

Yes No

Have you ever been convicted of a felony or misdemeanor?

Yes No

Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged?

Yes No

Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE or bungee jumping, or cave exploration?

Yes No

Do you participate in any aviation activity other than as a fare paying passenger?

Yes No

During the next 2 years do you intend to travel or reside outside of the USA for more than 2 weeks in a year?

Yes No

Initial: ______

Persona... | General ... | General ... | Health H... | Health H... | Health H... | Health H... | Medicati... | Chronic ... | Summary

- Risk Assessment

Health History - Proposed Insured

In the past 10 years have you ever been diagnosed, treated or taken medication for:

Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, shortness of breath, allergies or disorder of the nose or throat?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Initial: ______

Any disorder of the nervous system, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, brain or eye disorders, or headaches?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Initial: _____

Person... Genera... Genera... Health ... **Health ...** Health ... Health ... Medica... Chroni... Summ... Conflic...

- Risk Assessment

Health History - Proposed Insured (cont.)

In the past 10 years have you ever been diagnosed, treated or taken medication for:

Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including memory loss, Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)?

Yes No

PLEASE NOTE: Predictive text will suggest impairments when you start typing. Answers should be selected from this list.

Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Yes No

Any cancer, polyp, other tumors?

Yes No

Diabetes or high blood sugar?

Yes No

Initial: ______

Person... Genera... Genera... Health ... Health ... Health ... Health ... Medica... Chroni... Summ... Conflic...

- Risk Assessment

Health History - Proposed Insured (cont.)

In the past 10 years have you ever been diagnosed, treated or taken medication for:

Amputation due to disease or other medical condition?	Yes	No
Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome?	Yes	No
Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis?	Yes	No
In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, or been a member of a support group such as NA or AA?	Yes	No
Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease?	Yes	No
Do you have any pending appointments with any medical professional?	Yes	No

Initial: ______

Person... Genera... Genera... Health ... Health ... Health ... Health ... Medica... Chroni... Summ... Conflic..

- Risk Assessment

Health History - Proposed Insured (cont.)

Within the past 5 years have you:

Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, not including tests for exposure to the Human Immunodeficiency Virus (AIDS Virus)?

Yes No

Been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind?

Yes No

Do you currently:

Use or require the use of a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift?

Yes No

Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?

Yes No

Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation?

Yes No

Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion?

Yes No

Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia?

Yes No

Initial: ______

Person ... | Genera... | Genera... | Health ... | Health ... | Health ... | Health ... | Medica... | Chroni... | Summ... | Conflic...

- Risk Assessment

Chronic Illness Rider Supplement

Has a member of the medical profession ever treated you for or diagnosed you with:

Question		
Amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease)?	Yes	No
Huntington's chorea?	Yes	No
Parkinson's disease?	Yes	No
Multiple sclerosis?	Yes	No
Back pain, back surgery or back disease?	Yes	No
Chronic, recurrent or persistent memory loss or confusion?	Yes	No
Arthritis, including rheumatoid, psoriatic, or osteoarthritis?	Yes	No
Cognitive impairment?	Yes	No
Dementia?	Yes	No

Initial: _____

Emphysema?	Yes	No
Paralysis?	Yes	No
Stroke or mini stroke (transient ischemic attack, TIA)?	Yes	No
Osteoporosis with compression fracture(s) or other related fracture(s)?	Yes	No
Muscular dystrophy?	Yes	No
Chronic pain syndrome currently requiring treatment with narcotic medication(s)?	Yes	No
Chronic obstructive pulmonary disease (COPD)?	Yes	No
Myasthenia gravis?	Yes	No
Have you been hospitalized for any reason in the past 5 years?	Yes	No
Have you had or do you plan to have any joint replacement surgery?	Yes	No

Do you currently:

Reside in a long term care facility or nursing home or assisted living facility?	Yes	No

Initial: ______

Receive or require the services of a home health care provider or caregiver, including family member?	Yes	No
Receive, or have you applied to receive, any type of disability benefits?	Yes	No
Use, or require the use of a wheelchair, motorized scooter, walker, quad cane or stairlift?	Yes	No
Use, or require the use of oxygen or a respirator?	Yes	No
Use, or require the use of a dialysis machine?	Yes	No
Need, or receive help or supervision of another to perform personal care?	Yes	No
Need help or supervision of another to perform household chores?	Yes	No
Need, or receive help or supervision of another getting in or out of a bed or chair?	Yes	No
Have, or have you applied for, a handicap placard or handicap license plate?	Yes	No
Will this rider replace existing long-term care coverage now in force?	Yes	No
Will this rider replace existing Accelerated Benefits coverage now in force?	Yes	No

Signature: ____________________ **Date:** ___________