

**Medical Profile (only for groups not requiring individual health statements)**

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). **Please provide details to "Yes" answers in the space provided.**

**IMPORTANT:** Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have any employees or dependents been diagnosed or treated during the past five years for: <table style="width: 100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> Cancer/Tumor</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Back Disorder</td> </tr> <tr> <td><input type="checkbox"/> Heart/Circulatory</td> <td><input type="checkbox"/> Multiple Sclerosis</td> <td><input type="checkbox"/> Rheumatoid Arthritis</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Muscular Dystrophy</td> <td><input type="checkbox"/> Connective Tissue Disorder</td> </tr> <tr> <td><input type="checkbox"/> Reproductive Disorder</td> <td><input type="checkbox"/> Immune Disorder</td> <td><input type="checkbox"/> Lupus</td> </tr> <tr> <td><input type="checkbox"/> Intestinal Disorder</td> <td><input type="checkbox"/> AIDS/HIV+</td> <td><input type="checkbox"/> Growth Hormones</td> </tr> <tr> <td><input type="checkbox"/> Endocrine Disorder</td> <td><input type="checkbox"/> Chronic Lung Disorder</td> <td><input type="checkbox"/> Mental Health/Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Kidney Disease/Failure</td> <td><input type="checkbox"/> Organ Transplants</td> </tr> <tr> <td><input type="checkbox"/> Brain/Nervous</td> <td><input type="checkbox"/> Liver Disorders</td> <td><input type="checkbox"/> Congenital Disorders</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other Conditions _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Seizures	<input type="checkbox"/> Back Disorder	<input type="checkbox"/> Heart/Circulatory	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Connective Tissue Disorder	<input type="checkbox"/> Reproductive Disorder	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Lupus	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> AIDS/HIV+	<input type="checkbox"/> Growth Hormones	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Chronic Lung Disorder	<input type="checkbox"/> Mental Health/Substance Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease/Failure	<input type="checkbox"/> Organ Transplants	<input type="checkbox"/> Brain/Nervous	<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Congenital Disorders		<input type="checkbox"/> Other Conditions _____	
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Seizures	<input type="checkbox"/> Back Disorder																										
<input type="checkbox"/> Heart/Circulatory	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Rheumatoid Arthritis																										
<input type="checkbox"/> Stroke	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Connective Tissue Disorder																										
<input type="checkbox"/> Reproductive Disorder	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Lupus																										
<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> AIDS/HIV+	<input type="checkbox"/> Growth Hormones																										
<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Chronic Lung Disorder	<input type="checkbox"/> Mental Health/Substance Abuse																										
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease/Failure	<input type="checkbox"/> Organ Transplants																										
<input type="checkbox"/> Brain/Nervous	<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Congenital Disorders																										
	<input type="checkbox"/> Other Conditions _____																											
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births.																											
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have any employees or dependents been hospitalized or had any surgical operations during the past 5 years?																											
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?																											
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?																											
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation, Medicare and Medicaid?																											

**If you answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, continue your comments on the back side of this form.**

Question #	Check One Emp Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	\$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by Us.

**The insurer relies on the accuracy and timeliness of health information reported on this application to set premium rates. The Company must promptly notify the Insurer of any significant change in the health status - including but not limited to hospitalization - of an eligible employee or dependent that occurs after this application is submitted.**

I represent that, to the best of my knowledge, the information I have provided in this application - including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws - is accurate and truthful. I understand that the Insurer(s) will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences.

**Signature**

Employer Signature	Title	Date
--------------------	-------	------