

BOSWORTH & ASSOCIATES

UNIQUE RISK MANAGEMENT SOLUTIONS

1818 W.S.W. LOOP 323 Tyler, Texas 75701 (903) 561-2621 FAX # (903) 581-5369

HEALTH STATEMENT

Applicant's Name & Home Address	Date of Birth	Social Security Number
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Please list the names of all individuals requesting coverage. Use additional sheet for dependents if necessary. <input type="checkbox"/> Check here if sheet is attached.								
Applicant Name	Spouse:	Dependent Children:	M	F	Birthdate	Height	Weight	Do you use Tobacco?
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				
			<input type="checkbox"/>	<input type="checkbox"/>				

Please answer the following questions for each individual listed above. Please provide an explanation to all questions answered "yes" in the section below.		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Is diagnostic testing or an operation recommended or contemplated for anyone?
<input type="checkbox"/>	<input type="checkbox"/>	2. Is anyone pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	3. Is anyone taking any medications or receiving any treatment? If "Yes", list individual(s), all medications and dosages and indicate the underlying condition and/or type of treatment being received.
HAS ANY INDIVIDUAL:		
<input type="checkbox"/>	<input type="checkbox"/>	4. Had accident, health or life insurance modified, postponed, rated or declined? If "Yes", give complete details.
<input type="checkbox"/>	<input type="checkbox"/>	5. Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other disease of the heart or blood vessels (circulatory system)?
<input type="checkbox"/>	<input type="checkbox"/>	6. Been treated for mental, emotional or nervous disorder or depression?
<input type="checkbox"/>	<input type="checkbox"/>	7. Been treated for cancer, tumor or other malignancy?
<input type="checkbox"/>	<input type="checkbox"/>	8. Been treated for stroke, TIA (mini-stroke) or paralysis?
<input type="checkbox"/>	<input type="checkbox"/>	9. Been treated for emphysema, other respiratory or lung diseases or breathing conditions?
<input type="checkbox"/>	<input type="checkbox"/>	10. Been treated for diseases of the kidney, pancreas or liver?
<input type="checkbox"/>	<input type="checkbox"/>	11. Been treated for or diagnosed as having immunodeficiency (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorders?
<input type="checkbox"/>	<input type="checkbox"/>	12. Been diagnosed with diabetes? If "Yes", give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.
<input type="checkbox"/>	<input type="checkbox"/>	13. Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.
<input type="checkbox"/>	<input type="checkbox"/>	14. Been confined in a hospital, clinic, sanitarium or other medical facility?
<input type="checkbox"/>	<input type="checkbox"/>	15. Had any disease or impairment of or treatment for any of the following? If "Yes", check the appropriate box(es) below and explain using the space provided.
<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Bone/Joint <input type="checkbox"/> Epilepsy <input type="checkbox"/> Infertility <input type="checkbox"/> Lupus <input type="checkbox"/> Skin <input type="checkbox"/> Other		
<input type="checkbox"/> Back/Neck <input type="checkbox"/> Brain <input type="checkbox"/> Ears/Eyes <input type="checkbox"/> Intestines <input type="checkbox"/> Migraines <input type="checkbox"/> Stomach		
<input type="checkbox"/> Blood <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Neurological <input type="checkbox"/> Venereal Disease		
<input type="checkbox"/>	<input type="checkbox"/>	16. Does anyone have any known physical impairment or ill health not mentioned above? If "Yes", give complete details below.

Use this space below to provide complete details to any question answered "Yes" above. Indicate the number of the question; provide the name of the individual and complete details of the condition. Include dates of treatment, type of treatment and current condition. Use an additional sheet if required.

NO MATERNITY COVERAGE AVAILABLE FOR INDIVIDUAL HEALTH INSURANCE

Check here if additional sheet is attached.

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I agree that this document shall form a part of my request for insurance and I acknowledge that I have been given a copy of this document as completed by me. I understand that the information provided will not affect my eligibility to participate in this plan.

Signature:	Date Signed:
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