

Complete all spaces/answer Yes or No to all questions for yourself, your spouse and your dependent child(ren). If you are not applying for spouse/dependent children coverage, you do not need to answer questions for them. Circle all conditions which apply and provide details

Employee Height _____ Weight _____	Spouse Height _____ Weight _____	Child Name (first/last) Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	Child Name (first/last) Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____
Child Name (first/last) Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____		Child Name (first/last) Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	EMPLOYEE SPOUSE CHILDREN <small>If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.</small>
1. Have you used cigarettes or other tobacco products in the last 2 years?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
2. Are you pregnant? If "YES", give expected delivery date and describe complications.		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: high blood pressure; any disease or defect of the heart or blood vessels; diabetes; albumin, blood or sugar in the urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disorder of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; any immunodeficiency?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
4. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for AIDS or ARC (AIDS Related Complex)? Have you tested positive to the AIDS virus (including but not limited to Human T - Cell Lymphotropic Type III; HTLV - III; HTLV - IV; Human Immunodeficiency Virus (HIV))?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
5. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N

9. Name and address of **your** personal physician:

10. Name and address of your **spouse's** personal physician:

Date last seen and reason:

Date last seen and reason:

IMPORTANT: Provide details of all 'YES' answers given to questions stated above. If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

▲ _____
Employee Signature Date

▲ _____
Spouse Signature (if applying for coverage) Date

INFORMATION PRACTICES NOTICE

(retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Regence Life and Health Insurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.