

Answer the questions and sign below. All adult applicants must sign and submit this form with a completed Major Medical application. If questions 1-5 are answered "NO", a 30-day policy will issue effective the day following receipt of the completed application. If the Major Medical policy is issued within 30 days, the pro-rated premium from the Short Term Major Medical plan will be credited to the Major Medical policy premium.

<p><b>1.</b></p>	<p>Have/Are you, your spouse, or any person to be insured:</p> <p>Been denied insurance due to any health reasons that are still present?  Over 300 lbs. if male, or over 250 lbs. if female?  Now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>2.</b></p>	<p>Have you or any person to be insured been advised by a health care practitioner or medical professional to have surgery, treatment, testing or hospitalization and not done so?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>3.</b></p>	<p>Do you or any person to be insured have any hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>4.</b></p>	<p>Have you or any person to be insured ever been diagnosed or received treatment by a health care practitioner or medical professional for acquired immune deficiency syndrome(AIDS) or AIDS-related complex(ARC), or tested positive for HIV virus (ELISA or Western Blot), or any other immune system disease or disorder?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>5.</b></p>	<p>Within the last 5 years, have you or any person to be insured been aware of or received medical or surgical advice or treatment for, had any abnormal test results, taken medication for, or consulted a health care practitioner or medical professional for:</p> <p>Kidney disorder (excluding kidney stones) or liver disorder? ▪ Diabetes? ▪ Cancer or Tumors?  Emphysema or COPD? ▪ Crohn’s Disease? ▪ Alcoholism, Chemical Dependency, Drug or Alcohol Abuse?  Ulcerative colitis, degenerative disc disease, herniated disc or degenerative joint disease of the knees or hips?  Heart or circulatory disease or disorder including but not limited to heart attack, chest pain or stroke?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>6.</b></p>	<p>Has anyone applying for coverage previously applied for insurance with USL&amp;H?  <small>(If you answer "YES" to #6, this application will require further underwriting review. USL&amp;H will notify you of the policy status within 7 days.)</small></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

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Agent Signature

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Applicant Signature

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Dependent Signature

\_\_\_\_\_  
Dependent Signature

\_\_\_\_\_  
Dependent Signature