

MEDICAL DECLARATION

This Medical Declaration must be completed if you are between 70 and 84 years of age as of the effective date of coverage and are applying to purchase coverage for pre-existing medical conditions that have been stable in the 180 days prior to your effective date. Coverage for any pre-existing medical conditions is not available if you are over 84 years of age.

QUESTIONNAIRE

1. Was your most recent heart bypass, heart angioplasty (including stent placement) or heart valve surgery more than 10 years prior to your effective date?	Y	N
2. Have you been diagnosed with a heart condition as well as diabetes and/or hypertension (high blood pressure)? Answer NO if you have only diabetes/hypertension and do not have a heart condition.	Y	N
3. Have you ever had or are you awaiting a bone marrow or organ transplant?	Y	N
4. In the 24 months prior to your effective date have you been diagnosed with or treated for:		
a. Congestive heart failure?	Y	N
b. A lung condition with prednisone or other oral steroid medication (not including puffer) or home oxygen?	Y	N
c. Kidney or liver failure?	Y	N
d. Peripheral vascular disease?	Y	N
5. In the 12 months prior to your effective date have you been diagnosed with or been treated for:		
a. Angina, chest pain or a heart attack?	Y	N
b. Stroke, transient ischemic attack (TIA) or mini-stroke?	Y	N
c. Cancer (excluding basal or squamous cell skin cancer or breast cancer treated only with hormone therapy)?	Y	N
d. Internal bleeding?	Y	N

If you answered **Yes** to any of the questions above you are **not eligible** to purchase coverage for pre-existing medical conditions.

The applicant declares that, to the best of the applicant's knowledge, the statements and answers provided are truthful, complete and accurate. The applicant agrees that the statements and answers form part of the contract and that the insurance shall become effective in accordance with, and subject to, the terms and conditions of the policy. Misrepresentation or failure to disclose any material fact may void the policy at the option of the insurer.

Applicant Full Name	Date (MM/DD/YY)	Applicant Signature