Group Number	Social Security Number

Evidence of Health Status

CA-80124-HS 10/2006

This information should not be submitted more than 60 days prior to the effective date.

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 2-9 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Short-term income protection or Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications? ❍ No ❍ Yes
2. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months? ❍ No ❍ Yes
3. Have you or any dependent ever had, been diagnosed with, counseled, consulted or treated for any of the following:
   - a. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure? ❍ No ❍ Yes
   - b. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness? ❍ No ❍ Yes
   - c. Asthma or other disease of lungs or respiratory organs? ❍ No ❍ Yes
   - d. Kidney stones; disease of kidney, bladder, male or female organs; or infertility? ❍ No ❍ Yes
   - e. Cancer, and/or cancerous tumor? (state type; part of body) ❍ No ❍ Yes
   - f. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes? ❍ No ❍ Yes
   - g. Stomach, gall bladder, intestinal or colon disorders? ❍ No ❍ Yes
   - h. Rheumatoid arthritis or back disorders? ❍ No ❍ Yes
   - i. Phlebitis, paralysis, or any other physical impairment or deformity? ❍ No ❍ Yes
   - j. Alcoholism or substance abuse, or been a member of Alcoholics Anonymous? ❍ No ❍ Yes
4. Have you or any dependent been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years? ❍ No ❍ Yes

* CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned? ❍ No ❍ Yes
6. Are you or any dependent pregnant or ever had a cesarean section? ❍ No ❍ Yes
7. Please provide height/weight information for all applicants enrolling for coverage:

a. Employee name	Height (ft / in)	Weight (lbs.)
b. Spouse name	Height (ft / in)	Weight (lbs.)
c. Dependent name	Height (ft / in)	Weight (lbs.)
d. Dependent name	Height (ft / in)	Weight (lbs.)
e. Dependent name	Height (ft / in)	Weight (lbs.)

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets if necessary.

Question number	Person treated last name	First name
Condition		
List symptoms encountered		
List treatments received		
List medical tests administered		
Medication(s) if any		

Date condition was first diagnosed _ _ / _ _ / _ _ _ _ Date last seen by a doctor for this condition _ _ / _ _ / _ _ _ _

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)