



GROUP LIFE INSURANCE PROOF OF GOOD HEALTH

Please print or type all information. Signatures should be in blue or black ink.

Please fully complete this form if proof of good health is required or you are applying for any amount of Optional Life Insurance. The form must be dated and signed by the employee to be considered valid and is valid for no more than 90 days from the employee's signature date. A copy of the Basic Life Enrollment Form must be submitted with this form.

Additional medical information may be necessary and includes but is not limited to an independent medical examination, blood screen and/or urinalysis. Insurance will not become effective until the Perico Life Insurance Company has accepted this evidence as satisfactory and advises the applicant in writing of its approval.

Reason for Application: First Opportunity to Apply Change in Family Status Late Enrollee Rehire
 Increase in Existing Coverage Salary Change Other _____

Coverage Requested: Basic Employee Life Basic Employee AD&D Basic Dependent Life
 Optional Employee Life Optional Employee AD&D Optional Dependent Life Optional Dependent AD&D

POLICYHOLDER INFORMATION			
Policyholder (Employer Name):			Policy Number:
Employer's Street Address:		City:	State: Zip Code:
Original Effective Date of Group Life Policy:	Original Effective Date of Employee's Life Coverage (if applicable):	Policyholder's Telephone Number:	

EMPLOYEE INFORMATION			
Full Name:		Date of Birth:	Date of Hire: Social Security Number:
Street Address:		City:	State: Zip Code:
Gender: (M / F)	Occupation:	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	Employee's Home Telephone Number:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Annual Salary:	Hours Worked Per Week:	Employee's Work Telephone Number:
Physician's Name:		Physician's Address:	Physician's Telephone Number:

APPLICANT(S) INFORMATION					
Names of All Applicants	Social Security Number	Relationship	Date of Birth	Height	Weight
		Employee			
		Spouse			
		Child			
		Child			
		Child			

BENEFIT AMOUNT INFORMATION				
	Basic Life Amount In Force	Additional Basic Life Amount Requested	Optional Life Amount In Force	Additional Optional Life Amount Requested
Employee				
Spouse				
Child(ren)				



Policyholder Name:	Employee Name:
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MEDICAL INFORMATION				
Answer <u>Yes</u> or <u>No</u> to the following questions. For all "Yes" answers, please complete Medical Question Responses Section.				
#		Employee	Spouse	Child(ren)
1	At any time in the past 10 (ten) years, have you or any of your dependents been treated for any of the following conditions:			
	A. High blood pressure, heart disease, heart murmur, or any other disorder of the heart or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	B. Dizziness, chronic fatigue, fainting, convulsions, paralysis or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	C. Emphysema, tuberculosis, asthma or any other lung/respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D. Anemia or other blood ailments, endocrine disorders, diabetes, cancer, or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	E. Digestive disorder, rectal or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	F. Epilepsy, nervous system disorder or mental/nervous/emotional disturbance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	G. Disorders of the back or spine, bones, muscles or joints or arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	H. Substance abuse, including alcohol or drug dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have you or any of your dependents used any tobacco products in the past 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	In the past 10 years, have you or any of your dependents had any treatment or consultation for reproductive organs, intestine, liver or kidneys?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	In the past 10 years, have you or any of your dependents had any arrests for possession or use of non-prescribed or illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	In the past 10 years, have you or any of your dependents been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or any other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	In the past 5 years, have you or any of your dependents been hospitalized for any condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	In the past 5 years, has any medication been prescribed and taken on a regular basis for more than 3 consecutive months by you or any of your dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	In the past 5 years, have you or any of your dependents had any surgical procedures performed or recommended by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	To the best of your knowledge and belief, are you or any of your dependents currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Has insurance coverage ever been declined, postponed or issued with limitation or rating for you or any of your dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Do you or any of your dependents have any treatment or consultation by medical providers planned or scheduled for the next 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Have you or any of your dependents had any illness or injury, birth or congenital condition or disorder not previously indicated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL QUESTION RESPONSES				
(Use additional pages if necessary.)				
Question Number	Patient Name	Illness/Reason for Treatment or Consultation	Dates of Treatment From/To	Full Name and Address of Physician



Policyholder Name:	Employee Name:
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AUTHORIZATION

I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that coverage, if provided, is based on my statements. I understand that any material misstatements or my failure to provide information that is material to the provision of coverage may be used to rescind coverage or to contest a claim. I agree to notify the Insurance Company of any material change in my medical condition while my application for coverage is pending. I understand that coverage, if approved, will become effective under the terms of the group policy, including any applicable active work requirement.

I understand that no amount of Optional Life Insurance coverage will be in effect unless approved by Perico Life Insurance Company or its authorized representative.

I authorize any physician, health care provider, hospital, insurance company, reinsurance company and any employer to release to the Insurance Company or its reinsurers any and all medical information about me. I further authorize the Insurance Company to release this information to its reinsurers and to other insurance companies to which I have applied for coverage or benefits.

I understand that I may receive a copy of this authorization upon request, and I agree that a photocopy or electronic version of this authorization is as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to criminal and civil penalties, fines and confinement in state prison.

Signature of Employee:	Date:
Signature of Spouse:	Date:
Signature of Child(ren) 18 and over:	Date:
Signature of Child(ren) 18 and over:	Date:

For Perico Use Only	Underwriter:		Completed Date:
Employee	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Effective Date:
Spouse	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Effective Date:
Child(ren)	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	Effective Date: