Employee Health Questionnaire for Group Life Assurance

Name of Employer: _____ Name of Employee: _____

Date of Birth:_____ Present Occupation: _____

Height: _____ Weight:_____ Gain or Loss in Past Year: _____

Personal Physician's Name and Phone Number: _____

1.	Are you now in good health and entirely free from any mental or physical impairments or deformities?	Yes	No
2.	Have you ever suffered or do you now suffer from:		
	a) Diseases of the circulatory system (e.g. heart trouble, rheumatic fever, high blood pressure, diseases of the arteries and veins)?	Yes	No
	b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia)?	Yes	No
	c) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?	Yes	No
	d) Diseases of the gastro-intestinal system (e.g. digestive disorders, gastric or duodenal ulcer, disorders of the liver or gall bladder)?	Yes	No
	e) Diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown)?	Yes	No
	f) Diabetes, cancer, or any diseases of the blood, glands, spleen, ears or eyes?	Yes	No
	g) Any other diseases or ailments not mentioned above?	Yes	No
3.	If female, have you had or do you have any female disorders? Are you pregnant?	Yes	No
4.	Have you ever had or been advised to have hospital treatment or surgery?	Yes	No
5.	Have you consulted a physician for any reason, including routine examinations in the past 5 years?	Yes	No
6.	Have you ever received or do you now receive any disability benefit?	Yes	No

If you answered 'yes' to any of the above questions, please give complete details including dates, duration, treatment and the name a telephone number of your physician below:

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7. Has any proposal for a life insurance ever been made? If so, state name of the company, amount of insurance, and whether it was accepted as standard terms, with an extra premium, postponed, or declined?

The foregoing statements and answers are full, complete and true. I agree that they shall be the basis of the issuance of assurance for me under the Group Policy and The Life Assurance Company shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my request for assurance and withheld or concealed in the above statements.

I authorize any physician, nurse, hospital official or employee to disclose to the Life Assurance Company any and all information regarding my medical history.

_____	_____	_____
Name	Signature	Date