Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202 • (803) 735-1251

GROUP INSURANCE HEALTH STATEMENT

Employee Name: _____ Employee SSN: _____

Employee Date of Birth: _____ Group Name: _____ Group #: _____

You must provide the following health information to obtain the requested insurance coverage if:

(1) You are required by Companion Life to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life, STD, LTD) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. Please answer every question and complete every space.

Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.

Name and address of the Doctor or facility that has your medical records.

Employee's Doctor: _____ Address: _____

Spouse's Doctor: _____ Address: _____

Child's Doctor: _____ Address: _____

Employee: Height: _____ Weight: _____
Have you gained or lost more than 20 pounds in the last year?
☐ Yes ☐ No
If yes, amount ☐ gained or ☐ lost: _____ pounds
(Explain below.)

Spouse: Height: _____ Weight: _____
Have you gained or lost more than 20 pounds in the last year?
☐ Yes ☐ No
If yes, amount ☐ gained or ☐ lost: _____ pounds
(Explain below.)

Check *yes* or *no* for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Within the past 10 years has the proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	☐	☐	☐	☐	☐	☐
b. Applied for or received any disability compensation?	☐	☐	☐	☐	☐	☐
c. Flown or intended to fly as a pilot, student pilot or crew member?	☐	☐	☐	☐	☐	☐
2. Has the proposed Insured smoked cigarettes in the past 12 months?	☐	☐	☐	☐	☐	☐
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	☐	☐	☐	☐	☐	☐
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	☐	☐	☐	☐	☐	☐
5. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	☐	☐	☐	☐	☐	☐
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	☐	☐	☐	☐	☐	☐
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
d. Drug or alcohol dependency or abuse?	☐	☐	☐	☐	☐	☐
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	☐	☐	☐	☐	☐	☐
7. Have you ever been a patient in a hospital, sanitarium, or institution?	☐	☐	☐	☐	☐	☐
8. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	☐	☐	☐	☐	☐	☐
9. Have you ever had any surgical operations or had surgery advised but not performed?	☐	☐	☐	☐	☐	☐
10. To the best of your knowledge and belief, are you now pregnant?	☐	☐	☐	☐	☐	☐

11. Give the name and address of your personal physician and the date and reason for your last consultation.
Name: _____ Address: _____ Date: _____ Reason: _____

12. Details in connection with questions **3-8** answered "YES" above.

Question No.	Name	Date Mo. Yr.	Give Full Details for Each Question Answered "Yes" Including Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information	Name and Address of Physician or Hospital

I have _____ (number) children eligible as defined in the group policy.

All eligible children are free of any sickness, disease or injury, as defined in Questions 3 through 9 above, except as follows (Write "none" if all children do not need treatment or are free of impairments.): _____

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, Medicare Part A and Part B carrier that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life Insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

Witness _____ Date _____

_____ Date _____
Signature of Proposed Insured (or, if below age 15, parent or guardian)

PRE-NOTICE TO PROPOSED INSURED

Companion Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.