



INSTRUCTIONS:

1. Please print in ink.
2. All questions must be answered Yes or No. If Yes, underline the condition(s).
3. If necessary to evaluate a condition, a medical report may be requested from your physician. If the information received is insufficient, you will be required to supply an additional report.

MEDICAL QUESTIONNAIRE

Supplement to Group Subscriber Application or Change Request

Name of Employer or Group	Group No.	For Plan Use Only	DCN:
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LAST NAME	FIRST	MI	SOCIAL SECURITY NUMBER

Has anyone listed on the application ever had medical advice, treatment, or, to the best of your knowledge and belief, departure from good health in regards to any of the following:

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. NERVOUS - Brain disease, stroke, epilepsy-seizures, fainting or dizzy spells, cerebral palsy; other nervous system disorders. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. PSYCHIATRIC - Psychiatric counseling; marriage counseling; family therapy; addiction to narcotics; barbituates, amphetamines, or other drug dependency; nervous or mental disorders; alcoholism. |
| <input type="checkbox"/> | <input type="checkbox"/> | c. GENITOURINARY SYSTEM - Kidney, prostate, bladder, menstrual or other female disorders. |
| <input type="checkbox"/> | <input type="checkbox"/> | d. MUSCULOSKELETAL - Arthritis; rheumatism, bodily deformity; congenital abnormality; ruptured disc; or other muscle disorders. |
| <input type="checkbox"/> | <input type="checkbox"/> | e. CARDIOPULMONARY - High blood pressure; heart disease, circulatory disorders, lung disease; tuberculosis. |
| <input type="checkbox"/> | <input type="checkbox"/> | f. DIGESTIVE SYSTEM - Mouth; ulcers; disease of stomach; gall bladder; colon or intestines; hernia; rectum-hemorrhoids. |
| <input type="checkbox"/> | <input type="checkbox"/> | g. EYE, EAR, NOSE THROAT - Asthma; sinus; allergies; disease of nose or ears; disease of throat or tonsils; impairment of sight or hearing. |
| <input type="checkbox"/> | <input type="checkbox"/> | h. INCAPACITATION - Physical handicaps; mental retardation; or incapacitation as defined by Medicare. |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III). |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts. |
| <input type="checkbox"/> | <input type="checkbox"/> | k. MISCELLANEOUS - Tumor or mass, cancer / liver disorders; thyroid disorders; blood disease; diabetes; skin disorders; infections. |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Is anyone listed on the application pregnant? If yes, when is expected due date? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Has anyone listed on this application: |
| | <input type="checkbox"/> | 1. had medical advice, examination, treatment or departure from good health not mentioned in the questions above in the last 5 years? |
| | <input type="checkbox"/> | 2. ever been advised to undergo a surgical operation which was not performed? |
| | <input type="checkbox"/> | 3. been scheduled for surgery or advised to have surgery within the next 6 months? |
| | <input type="checkbox"/> | 4. been refused or had health insurance cancelled within the last 5 years for health reasons? |
| | <input type="checkbox"/> | 5. been refused life insurance? |
| | <input type="checkbox"/> | 6. been a patient in a hospital, clinic, sanitarium, or other medical facility during the past 10 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Are you currently taking any prescription drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Is anyone listed on this application disabled? If yes, give name of the individual and specify the underlying cause: |

Name _____

Cause _____

I HAVE ANSWERED ALL QUESTIONS CORRECTLY FOR EVERY PERSON LISTED ON THE APPLICATION.

Signature _____

Complete this section for all dependent(s) for whom application or change is being made:

LAST NAME	FIRST	MI	DATE OF BIRTH			HEIGHT		WEIGHT
			MO	DAY	YR	FT.	IN.	
APPLICANT'S			DATE OF BIRTH			HEIGHT		WEIGHT

Give full details below to any questions answered "YES" above. If additional space is needed list on separate sheet and attach to this application.

PERSON TREATED	DIAGNOSIS/CONDITION TREATED	DATE OCCURRED	TREATMENT RENDERED	DATE OF LAST TREATMENT	NAME AND ADDRESS OF PHYSICIAN
FAMILY PHYSICIAN'S NAME			ADDRESS		

I declare that all statements made hereon are complete and true to the best of my knowledge and belief, and understand that any misstatements or omissions may void all coverage applied for.

I agree that the Plan may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Plan for any benefit payment made on behalf of any such member.

By check the appropriate block, I indicate whether or not I understand that: no person covered will receive any benefits for a disease or physical condition which he or she has or had in the past, until he or she has had continuous coverage for 12 months under this and any prior Greater Georgia Life contracts, unless waived under the Group Master Contract.

- I DO UNDERSTAND I DO NOT UNDERSTAND

APPLICANT'S SIGNATURE _____ DATE SIGNED _____ DAYTIME PHONE NO. _____

**ABBREVIATED NOTICE OF INSURANCE
INFORMATION PRACTICES**

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. We are required by law to keep your data confidential. It will be seen only by our employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practice, please contact Greater Georgia Life Insurance Company, Customer Service Department, Post Office Box 4445, Atlanta, Georgia 30302.