

SIMPLIFIED
SPL2-336-XX

HEALTH QUESTIONS: Please read the Instructions Carefully.

<i>Applicant Name</i>	<i>Applicant Social Security Number</i>

INSTRUCTIONS: You must answer each question by checking YES or NO.

1. Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions: YES NO

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| <ul style="list-style-type: none"> • Diabetes Treated with Insulin • Any Diabetes with Skin Ulcers • Multiple Joint Replacements OR Any Joint Deformities • Kidney Disease • Liver Cirrhosis • Hepatitis B, C, D, or E • Stroke or Transient Ischemic Attack (TIA) | <ul style="list-style-type: none"> • Memory Loss, Alzheimer's Disease, or Dementia • Bipolar Disorder, Schizophrenia, Psychosis, Mental Retardation • Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis • Multiple Sclerosis • Parkinson's Disease/Parkinsonism • Muscular or Neurological Conditions causing Limits | <ul style="list-style-type: none"> • Post-Polio Syndrome • Lupus (SLE) • Scleroderma • Amputation-Due to Disease • Organ or Bone Marrow Transplants • Brain or Spinal Tumors-benign or malignant • Metastatic Cancer, Multiple Myeloma • Pulmonary Embolism • Carotid Artery Disease | <ul style="list-style-type: none"> • Peripheral Vascular Disease • AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS. |
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2. In the PAST YEAR: Have you needed assistance or supervision in taking medication, performing activities of daily living* OR used any Medical Equipment?** YES NO

*Activities of Daily Living Include Bathing, Dressing, Eating, Toileting, Getting In and Out of Bed, Bowel OR Bladder Control
**Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications.

3. In the PAST YEAR: Have you been admitted to a nursing home, assisted living facility, psychiatric hospital, OR alcohol/drug rehabilitation? YES NO



STOP! If questions 1,2 OR 3 are checked "Yes," we cannot offer coverage at this time. Do not Submit the Application.

4. In the PAST YEAR: Have you been hospitalized overnight (except for uncomplicated childbirth) OR been advised to have surgery, OR been diagnosed with cancer AND received OR been advised to receive Radiation or Intravenous Chemotherapy? YES NO

5. In the PAST YEAR: Have you been referred to or received medical advice, consultation or treatment from any physician specializing in any of the following: Neurology (Nerves), Nephrology (Kidney/Renal), Pulmonary (Respiratory), OR Hematology (Blood)? YES NO

6. In the PAST YEAR: Have you been declined, postponed, or had your benefits modified for a long term care application? YES NO

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.
CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

To the best of my knowledge and belief, I have answered all questions completely and truthfully.

Dated at:	City	State	Month	Day	Year
APPLICANT'S SIGNATURE:					