

♦ **GENERAL INFORMATION**

Full Name of Proposed Insured: _____
 Address: _____
 Date of Birth: _____ Height: _____ Weight: _____
 Occupation: _____ Social Security Number: _____
 Policy Number: _____ Medical Number: _____

♦ **MEDICAL INFORMATION**

Name & Address of Physician(s) (If None, state None)	Reason Consulted	Dates Seen	Medication or Treatment Given (If None, state None)

1) Have you been continuously and actively at work on a full time basis (minimum 30 hours per week) at the occupation specified above for the last 90 days? Yes No (If "No", give details)

2) Have you ever been told you had, or had reason to suspect that you had, consulted with, or been treated by a doctor for any of the following: Cancer; High Blood Pressure; Ulcer; Tumor; Diabetes; Glandular Disorder; Any Brain or Nervous System Disorder; Heart Attack; Chest Pain or Heart Disorder; Any Disorder of the Kidneys, Lungs, Blood, Liver; Any Drug or Alcohol Habit; Acquired Immunodeficiency Syndrome (AIDS); or a Disease of the Immune System? Yes No If "Yes", give details

3) Have you ever used barbituates, heroin, narcotics, amphetamines, cocaine, or any drugs except prescribed by a Physician? Yes No If "Yes", give details

4) Within the last 3 years, have you engaged in or do you contemplate engaging in: skydiving, skindiving, or scubadiving; motorcycle or auto racing; hang gliding; or any other hazardous sport or hobby?
 Yes No If "Yes", complete the avocation questionnaire.

5) Within the last 3 years, have you flown or do you contemplate flying other than as a fare-paying passenger on a commercial airline? Yes No If "Yes", complete the aviation questionnaire.

6) Since the issuance of the above numbered policy, has the insured made an application for life insurance which was declined, postponed or accepted at extra premium?
 Yes No If "Yes", Company Name _____
 Reason for adverse action: _____

♦ **AUTHORIZATION TO RELEASE INFORMATION**

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to Vantis Life or its reinsurers, or its legal representatives. Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person. I understand that the information released to Vantis Life or its reinsurers or its legal representatives will be used to determine my eligibility for the insurance requested. Vantis Life may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of Vantis Life. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any information relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photocopies of it will be valid for two and one half years following the date signed, unless otherwise required by law. The information released to Vantis Life will not be given, sold or transferred to any other person not mentioned above.

X	X	
Signature of Proposed Insured	Signature of Owner (if different from Proposed Insured)	Date