



To be completed by the Proposed Insured

Name of Applicant _____ Date of Birth _____

Group Name _____ Group # _____ Member # _____

1. Have you ever had or been told you have cancer, dysplasia, tumor(s) or leukemia? Yes No
Indicate whether Malignant or Benign
If "Yes", give the date and diagnosis: _____

2. Where was the original site of the cancer? _____ To which body areas has it spread? _____

3. Stage: _____ Thickness: _____
Level: _____ Lymph node involvement? Yes No If "Yes", indicate number of lymph nodes involved. _____
If Prostate cancer: What is your current PSA level? _____ What was the Gleason score? _____

4. Treatment recommended: Chemotherapy Date(s) Received: _____
 Radiation Date(s) Received: _____
 Other _____ Date(s) Received: _____

Have you received high-dose chemotherapy with bone marrow or stem cell infusion? Yes No
Has this form of treatment been advised or discussed? Yes No

5. Has surgery been recommended or performed? Yes No
If "Yes", provide details, including type and date of surgery or procedure. _____

6. Date and results of last checkup: _____

7. Are you currently in remission? Yes No
If "Yes", the date your doctor told you that you were cancer free with no further evidence of disease: _____

8. Current treatment, medication: _____

9. Do you still have any symptoms or recurring after-effects from the disorder or treatment for the disorder named in question 1?
 Yes No Please give specific details. _____

10. List the dates, names, addresses and phone numbers of all doctors consulted.
Initial Treating Physician(s): _____ Follow-Up Physician(s): _____

11. Is the disease or treatment affecting your ability to work on a full-time basis? Yes No

12. Have you smoked or used tobacco products during the past 12 months? Yes No

I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued and that any incorrect answers may operate to void this insurance.

Signature of Proposed Insured _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this medical history. Thank you.