



**F** **Portability Information:** Complete to determine appropriate reduction of this plan's pre-existing condition limitation. Attach certification of creditable coverage from your prior plan if you are a new enrollee under the above employer's plan.

Prior Coverage Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Covered Individuals: \_\_\_\_\_ Prior plan or carrier name: \_\_\_\_\_

Reason for ending prior coverage: \_\_\_\_\_

**G**

1. Are you now actively at work on a full-time basis?  Yes  No

2. Is any dependent currently disabled or unable to perform their normal activities?  Yes  No

3. Have you or any dependent ever been postponed or refused medical or life insurance?  Yes  No

4. Have you or any dependent, **in the last 10 years**, received treatment (including medication) or been told by a member of the medical or mental health profession that you had:

a) Disorders of the heart or blood vessels, chest pain, or high blood pressure?  Yes  No

b) Paralysis, epilepsy, Parkinson's disease, nervous system disorders, or migraine headaches?  Yes  No

c) Tumor, cancer or any malignancy, diabetes, kidney or liver disorders?  Yes  No

d) Mental disorders, depression or other emotional disorders, alcohol or other drug abuse or addictions?  Yes  No

e) Stomach, intestinal, or gall bladder disorders, rheumatism, arthritis, back or spinal disorders?  Yes  No

f) Tuberculosis, asthma, shortness of breath, or other respiratory disorders?  Yes  No

5. Are you or any dependent currently pregnant?

a) Have you or any dependent, in the last 10 years, received treatment (including medication), or been told by a member of the medical profession that you had: infertility, premature delivery, miscarriage, c-section, or any other complications of pregnancy?  Yes  No

6. HAVE YOU OR ANY DEPENDENT to be covered by this insurance had any other injury, illness, treatment, or been hospitalized during the past 10 years which is not listed above or anticipate treatment or surgery?  Yes  No

7. Have you or any of your dependents, in the last 10 years, been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any sexually transmitted disorder?  Yes  No

**If any of the above questions are answered "YES", please indicate the following information: (1) The attending physician name and address; and (2) Any additional details or information concerning diagnosis or treatment. Attach additional page if needed.**

PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
PHYSICIAN/HOSPITAL NAME	PHYSICIAN'S CLINIC AFFILIATION	CITY AND STATE	
PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
PHYSICIAN/HOSPITAL NAME	PHYSICIAN'S CLINIC AFFILIATION	CITY AND STATE	
PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
PHYSICIAN/HOSPITAL NAME	PHYSICIAN'S CLINIC AFFILIATION	CITY AND STATE	

**H** **Authorization to Obtain Medical Information**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, organization, institution or person, that has any records or knowledge of me, my spouse, or my minor children to give to Midwest Security Life Insurance Company or its reinsurers, any and all such information. To facilitate the rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by Midwest Security Life Insurance Company to collect and transmit such information.

I understand the information obtained by use of the Authorization will be used by Midwest Security Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by Midwest Security Life Insurance Company to any person or organization except to reinsuring companies, the Plan Administrator, Plan sponsor, insurance intermediaries, or other persons or organizations performing business or legal services in connection with my application, claims plan renewal, or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that I have received a copy of the Authorization to Obtain Medical Information. I agree this Authorization shall be valid for two and one half years from the date shown below and that a copy of this Authorization shall be as valid as the original.

**A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Signed this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant  
(or parent or guardian if proposed insured is a minor)

\_\_\_\_\_  
Signature of Spouse