Alta Health & Life Insurance Company
P.O. Box 40926, Jacksonville, FL 32203-0926

A STATEMENT OF HEALTH MADE TO OBTAIN GROUP INSURANCE
Please retain copy for your records. Please print.

TO BE COMPLETED BY PERSON TO BE INSURED (STATE EMPLOYEE ONLY)

Employer's Agency / Department Name	Employee's Social Security Number	Employee's Occupation	
Employee's Name and Address			
Employee's Birth Date / /	Employee's Place of Birth City / State Country	Employee's Height ft. in.	Employee's Weight lbs.

If the answer to any of the following is "yes", give details where indicated below.
During the past five years have you had or been told you had, or been treated for any of the following:

	Yes	No
1. High blood pressure, heart murmur, pain or pressure in the chest, or any disorder of the heart or arteries?	☐	☐
2. Cancer or multiple sclerosis?.....	☐	☐
3. Pleurisy, blood spitting, asthma or emphysema?.....	☐	☐
4. Any blood, thyroid, glandular or breast disorder?.....	☐	☐
5. Have you been diagnosed or sought treatment for HIV, or any retrovirus; AIDS, ARC, or any disorder of the immune system?	☐	☐
6. Any disorder of kidneys, bladder, generative organs, or syphilis?	☐	☐
7. Any disorder of stomach, gall bladder, liver, intestine, appendix or rectum?	☐	☐
8. Nervous breakdown or other disorder of nervous system?.....	☐	☐
9. Any bone or joint disorder, rheumatism or gout?	☐	☐
10. Any impairment of sight or hearing?	☐	☐
11. Have you ever been examined for or made application to any insurance company for life, accident, or health insurance without receiving the exact policies applied for; or been declined for reinstatement or renewal of any policy?	☐	☐
12. Have you ever had or been advised to have a surgical operation for any reason not already mentioned during the past five years?	☐	☐
13. Have you been in a hospital, asylum, sanitarium, or other institution for observation, treatment or diagnosis for any reason not already mentioned during the past five years?	☐	☐
14. For female lives only: Are you now pregnant?	☐	☐
15. Have you consulted or been treated by a physician or practitioner during the past five years?	☐	☐

Give details here where Yes is indicated above.

No.	Condition	Dates	Treatment & Results	Physician or Hospital	Address

Be Sure to Answer All Questions

I, the person requesting coverage, acknowledge that the above statements are true and complete to the best of my knowledge and belief and it is agreed that such statements and answers are a part of my request for, and shall be used as a basis for underwriting any coverage that may be granted. I also acknowledge that Alta Health & Life Insurance Company has furnished me a copy of this instrument containing my answers, statements and explanations.

City/State signed at _____ Date _____ Employee's Signature _____

AUTHORIZATION

Please give to Alta Health & Life Insurance Company all information it may request regarding the medical history and physical condition of:

Employee's Signature _____

A photographic copy of this authorization shall be considered as valid as the original. Thank you for your courtesy.

Employee's Signature _____

Employee's Address _____