

### Hospital Indemnity Health Questions

1. In the past 12 months have you been confined as an inpatient to a hospital, nursing home or have you received home health care, been bedridden or confined to a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 12 months have you been treated for chronic obstructive lung disease, emphysema, Parkinson's Disease, neuromuscular or neurological Disease, insulin dependent diabetes, Alzheimer's disease, ulcerative colitis, cirrhosis or other chronic liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 12 months have you had surgery or have you been advised to have surgery, including pending biopsy or any pending diagnostic testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 24 months have you had or been treated, including injection therapy, for heart attack, stroke, transient ischemic attack, (TIA), heart surgery, congestive heart failure, rheumatoid arthritis, kidney disease, malignant melanoma, internal cancer, autoimmune disorder or osteoporosis causing fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 24 months have you received medical advice, treatment or counseling relating to Schizophrenia, psychotic disorder, bipolar/manic depression, alcohol or substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) or Human Immunodeficiency Syndrome (HIV) Infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you taking or have you taken any prescription drugs or over-the-counter medications within the last 12 months? If yes, please list the drug and condition. _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 2 years, have you had a Hospital Indemnity insurance application postponed, rated up or declined? If yes, please provide us with details. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No