



P.O. Box 830619  
Birmingham, AL 35283-0619

**SUPPLEMENTAL UNDERWRITING APPLICATION**

**PROPOSED INSURED:**

First Name	M.I.	Last Name	Date of Birth:
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**Important! For ALL QUESTIONS ANSWERED YES, please provide details including: Name of physician, date diagnosed, medications, and current condition. If additional space is needed, please use the Continuation of Information form.**

**1. Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:** Yes No

a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome? ☐ ☐

DETAILS: \_\_\_\_\_

b) Connective Tissue, Lupus or other auto-immune disorder? ☐ ☐

DETAILS: \_\_\_\_\_

c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, ALS, Multiple Sclerosis, Aphasia or other disorders of the brain or nervous system? ☐ ☐

DETAILS: \_\_\_\_\_

d) Any history of fractures or falls? ☐ ☐

DETAILS: \_\_\_\_\_

**2. Has the Proposed Insured been:**

a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance? ☐ ☐

DETAILS: \_\_\_\_\_

b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months? ☐ ☐

DETAILS: \_\_\_\_\_

c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care? ☐ ☐

DETAILS: \_\_\_\_\_

	Yes	No
<b>3. Does the Proposed Insured:</b>		
a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If Yes, provide type of device and date usage began)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
b) Participate in any type of exercise program? (If Yes, provide type and frequency)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
c) Drive a motor vehicle? (If Yes, provide the number of miles driven in the past 12 months. If No, what date did you last drive and why did you stop driving?)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
d) Manage finances, including paying bills, writing checks and balancing the check book? (If No, identify what activities require assistance, who provides it and why it is needed.)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If No, identify what activities require assistance, who provides it and why it is needed.)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
f) Live alone? (If No, who do you live with?)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS: _____		
<b>4. Does ANYONE help the Proposed Insured with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If Yes, identify the helper and give details of help required)</b>		
		<input type="checkbox"/> <input type="checkbox"/>
DETAILS: _____		
<b>5. Is the Proposed Insured's activity limited by shortness of breath or pain? (If Yes, explain)</b>		
		<input type="checkbox"/> <input type="checkbox"/>
DETAILS: _____		
<b>6. How far can the Proposed Insured walk without needing to stop and rest on level ground? (If Yes, how long would it typically take to walk this distance in seconds?)</b>		
a) 50 feet or ½ block. DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
b) 100 feet or one block. DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
c) 400 feet or four blocks. DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Additional details or comments:</b>		
The above statements and answers are true and complete to the best of my knowledge and belief.		

Signed at (City/State): \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Proposed Insured: \_\_\_\_\_



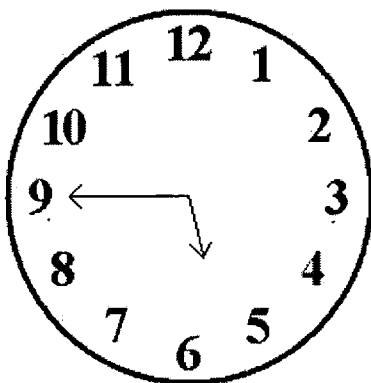
## Landmark Drawing Copy Test

Proposed Insured \_\_\_\_\_

Policy Number \_\_\_\_\_

*Note to the Examiner: This test must be completed free-hand, with only an eraser-tipped pencil and no other assistive devices.*

PROPOSED INSURED'S NAME (Please Print)	Date of Birth
Instructions: <b>COPY</b> the <b>DRAWING</b> below in the area provided to the right.	



I certify that I alone have completed this test with only an eraser-tipped pencil and no other devices, without the assistance of the examiner or any other person(s).

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
(City, State)

Signed in the  
presence of

\_\_\_\_\_  
(Signature of Medical Examiner)

\_\_\_\_\_  
(Signature of Proposed Insured)