

**EMPLOYEE'S STATEMENT OF PHYSICAL CONDITION
WESTERN MUTUAL INSURANCE COMPANY**

P.O. Box 572450; Murray, Utah 84157
Phone: (801) 263-8000 Fax: (801) 263-1247

EMPLOYEE INFORMATION (Please Print)

Employee Name _____ Employer _____

Employee Address _____
Street City State Zip

Date of Employment _____ Job Title _____ Hours Worked Each Week _____

Home Phone _____ Work Phone _____

Social Security No. _____ Marital Status: Single Married Separated Divorced

Date of Birth _____ Height: _____ Ft. _____ In. Weight _____

Gender: Male Female Medical Coverage is for: Myself only Myself and my spouse Myself and my child(ren) Myself, Spouse and my child(ren)

DEPENDENT INFORMATION

Full Name*	Relationship to Employee	Social Security Number	Gender	Birth Date	Height & Weight	Other Medical Insurance	Name of Other Insurance Carrier
					____ Ft. ____ In. Weight _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					____ Ft. ____ In. Weight _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					____ Ft. ____ In. Weight _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					____ Ft. ____ In. Weight _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

* To be eligible for coverage, children must be the dependent age provided by statute, unmarried, and dependent upon you for 50% of their support. ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.

PREEXISTING CONDITION EXCLUSION AND PORTABILITY CREDITS: Benefits may not be payable for preexisting conditions for a period of twelve (12) months (six (6) months in New Mexico) following your effective date of coverage (eighteen months for a late enrollee). A preexisting condition is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to the enrollment date of coverage. If a preexisting provision applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage. WMI will assist you in obtaining the certificate from your prior plan, if necessary. To obtain additional information regarding the preexisting condition exclusion, please contact Kellee Howell, Claims Department, (801) 263-8000 x116 or (800) 748-5340 x116. If you have had health coverage within the last sixty-three (63) days, please enclose proof of any prior coverage dating up to eighteen (18) months prior to this application and provide the following information:

Policyholder's Name _____ Policy No. _____ Name of Carrier _____

AUTHORIZATION

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with Western Mutual Insurance Company ("WMI"). I understand no coverage will be in force until each person listed above is approved by WMI, that no benefits will be provided for any service which begins before the coverage is effective, and that benefits will not extend beyond the termination of my coverage. I understand that omissions or misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or void any coverage issued.

I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, or insurance company to disclose to WMI or its representatives all information and records of myself and my dependents relating to diagnosis, treatment, medical history, physical or mental condition, and evaluation thereof for which coverage by WMI is sought. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. This authorization shall remain valid for a period not to exceed twenty-four (24) months. A copy of this authorization shall have the same effect as the original.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the Health Information on the back side of this application, is correctly recorded, true and complete. If I subsequently become aware of information different from that provided in this application, I agree to provide that information promptly to WMI. I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information that is provided on this application.

EMPLOYEE SIGNATURE _____ DATE _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

HEALTH INFORMATION: Answer every question for each individual applying for coverage. Circle any specific item(s) in the question that applies. Give full details to any “YES” answer in the space provided below.

- | | <u>YES</u> | <u>NO</u> | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Is anyone currently under medical care or treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Has anyone had cancer, tumors, cysts, or growths (except for warts), breast lump, or any kind of skin disorder that required medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other health care provider within the past three years? | <input type="checkbox"/> | <input type="checkbox"/> | 16. In the past 5 years, has anyone had diabetes, gout, arthritis, thyroid disorder or a disorder of the lymph nodes or lymph system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is anyone currently taking any medicine, drugs or shots? | <input type="checkbox"/> | <input type="checkbox"/> | 17. In the past 5 years, has anyone had any back, neck or spinal problems or a joint disorder that required medical attention? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has anyone been advised to be hospitalized, have tests, have surgery or take medication but has not done so? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Has anyone had a blood disorder, tested positive for HIV, or been treated for or diagnosed with AIDS, AIDS Related Complex (ARC) or disorder of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has anyone been hospitalized or had surgery in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Has anyone ever had any heart trouble, heart attack, circulatory problems, or any blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is any family member now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | 20. In the past 5 years, has anyone had chest pain, rapid slow or irregular heartbeat, or high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has anyone been evaluated for infertility or is anyone infertile? Has anyone ever had a C-section or a miscarriage? | <input type="checkbox"/> | <input type="checkbox"/> | 21. In the past 5 years, has anyone had any surgery, or treatment for obesity, bulimia, anorexia, or weight control? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has anyone had or does anyone have any birth defect, developmental or learning disability, or physical or mental impairment(s)? | <input type="checkbox"/> | <input type="checkbox"/> | 22. In the past 5 years, has anyone had tuberculosis, asthma, pleurisy, emphysema, or any disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the past 5 years, has anyone had gallbladder problems, ulcers chronic diarrhea, colitis, rectal disease, other digestive problems, pancreas problems, hepatitis, cirrhosis, liver problems, hernia, stomach stapling or gastric bypass? | <input type="checkbox"/> | <input type="checkbox"/> | 23. In the past 5 years, has anyone been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the past 5 years, has anyone been treated for use or abuse of drugs or alcohol or substance abuse or been told by any professional to reduce the use of alcohol, drugs or other substances? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Does anyone smoke or use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. In the past 5 years, has anyone had a kidney disorder, urinary problems, albumin or sugar in the urine, pelvic inflammatory disease, incontinence, any disorder of the reproductive system, or venereal or other infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 25. In the past 5 years, has anyone been denied or turned down for other health or life insurance or been given a modified or rated policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. In the past 5 years, has anyone been unconscious or had epilepsy, seizures, or convulsions? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Are you or your spouse financially responsible for an unborn child or anticipating adoption? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. In the past 5 years, has anyone had depression, stress, or anxiety that interfered with daily life or received any counseling, psychotherapy or had a mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Does anyone have a condition not indicated above for which medical treatment, counseling or care has been recommended or received in the past 5 years, or is expected to be received by any person applying for coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone have multiple sclerosis or muscular dystrophy? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ADDITIONAL INFORMATION -- Must be completed for any “YES” answer above.

Question Number	Full Name of Individual	Diagnosis of Illness or Injury, Treatment, Testing or Medical Attention (<i>Be specific</i>)	Date Began (mm/dd/yy)	Date Ended (mm/dd/yy)	Remaining Symptoms or Problems	Name, Address and Phone of Doctor or Hospital

PRESCRIPTION DRUGS

Full Name of Individual	Name of Medication	Dosage	Date Began (mm/dd/yy)	Date Ended (mm/dd/yy)	Reason for Medicine	Name, Address and Phone of Prescribing Doctor

LIST BELOW ANY DEPENDENTS WHO ARE NOT APPLYING FOR COVERAGE

Full Name of Individual	Relationship to Employee	Gender	Birth Date	Current Health Status