Health Questionnaire for ages 65-80

**Prior to completing this health questionaire, please note that failure to disclose material information (i.e. information that would influence the acceptance of the risk and/or terms applied) could void insurance policy. If you are in doubt as to whether any information is material, it should be disclosed.*

Name:______________________________ Height:_______ Weight:_______Date ofBirth:____/____/_______

Primary Care Physician:________________________Office Number:_______________Occupation:________________

Circle YES or NO as appropriate. ***Please include details for all yes responses.***

1. Does the person to be insured have any **PAST** or **PRESENT** medical history?..**YES** or **NO**

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2. Have any surgical history? (Including all minor and/or outpatient procedures)..**YES** or **NO**

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____

3. Take any medications on a daily basis? (Please list all medications and doses)..**YES** or **NO**

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____

4. Have any known drug Allergies? (Please list below)..**YES** or **NO**

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5. In the past 24 months have you sought medical attention for any illness or injury...**YES** or **NO**

____

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6. Have you been hospitalized within the past 24 months..**YES** or **NO**

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7. Drink Alcohol and/or Tobacco products daily? ....**YES** or **NO**

8. Have impaired vision and/or hearing? ....**YES** or **NO**

9. Have a **Pacemaker**, **defibrillator**, or **prosthetic device**? ....**YES** or **NO**

10. Has your request for any insurance (Accident, Medical, or Life) ever been denied or terminated....................**YES** or **NO**

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11. At any time has your current insurer imposed special conditions or increased your premium.........................**YES** or **NO**

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***DECLARIATION*:** I declare to the best of my knowledge and belief the above statements and particulars are true and complete.

Signature: ____ Date: ________________________________