

Health Questionnaire

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098



MINNESOTA LIFE

Return Completed Application To: OCHS, Inc. • 400 Robert Street North • Suite 1880 • St. Paul, Minnesota 55101-2098

Please Print

Employee name (last, first, middle initial)	Height	Weight	Employee Social Security number	Email address
Spouse name (last, first, middle initial)	Height	Weight	Spouse date of birth	Email address

Complete for Dependent Child(ren) Coverage - List Oldest to Youngest

Child's Name	Child's Date of Birth	Child's Name	Child's Date of Birth

HEALTH QUESTIONS

In answering the following questions, you need not disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the back of this application for a definition of "emergency medical personnel".

EMPLOYEE		SPOUSE		CHILD		
YES	NO	YES	NO	YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. During the past 5 years, have you: (please check) for any reason <input type="checkbox"/> consulted a physician or other health care provider, or <input type="checkbox"/> been hospitalized, <input type="checkbox"/> been advised to have surgery, or <input type="checkbox"/> received any medication?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, been treated, advised to seek treatment for, or received any medication for any of the following: heart, lung, nervous, kidney or liver disorder, high blood pressure, drug or alcohol abuse including addiction, cancer or tumor, diabetes, stroke, epilepsy, hernia, digestive ulcer, emphysema, allergies, arthritis, or headaches? Any disease or disorder of the back, brain, stomach, intestinal track, genitourinary system, glands including lymph gland enlargement, spleen, bone, muscle or blood?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever been diagnosed as having AIDS or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?
<input type="checkbox"/>	<input type="checkbox"/>					4. If female, are you pregnant?

NOTE: If your answer to any question is YES, please complete the reverse side of this form.

Physician's name	Telephone number
Physician's address	

AUTHORIZATION

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company or Assurant Employee Benefits, (the Companies), shall incur no liability because of this application unless and until it is approved by the Companies and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Companies and their reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Companies to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Companies. This authorization is valid for 26 months. This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. A photocopy shall be as valid as the original. I have read this and the Consumer Privacy Notice and I understand that I can have copies.

Employee signature X	Date signed	Daytime telephone number ()
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