



CENTRAL RESERVE LIFE INSURANCE COMPANY
HEALTH HISTORY QUESTIONNAIRE

Applicant (Proposed Insured): _____

Company/Employer: _____

If you have answered "Yes" to any of the questions listed on the Insurance Enrollment Application, complete the appropriate section(s) of this Health History Questionnaire. All questions related to the medical condition(s) must be answered in detail. Please contact the doctor if you are unsure about the answer to any of the following questions.

1. Arthritis/Disorders of the Back, Knees, Bones, Muscles, Ligaments, Tendons, Cartilage, Joints:

Person with condition: _____

- A. Medical condition (diagnosis)? _____
B. Date of onset? _____
C. Exact location? (Indicate upper, middle, lower, left, right, etc.) _____
D. For arthritis, type of arthritis? _____
E. For Scoliosis, what is degree of curvature? _____
F. Type, frequency and date(s) of treatment (other than medication)? _____
G. Name medication(s) currently or previously taken: _____
H. Is medication being taken: [] on a continuous basis, or [] as needed? Frequency? _____

- I. If surgery was performed, type and date of surgery? _____
J. Any restriction in movement or activity? _____
K. Any deformity? - Define: _____
L. Any time lost from work? _____ If so, duration? _____
M. Degree of recovery? _____
N. Date of last occurrence? _____
Number of occurrences per year: _____
O. Type of future treatment and/or testing anticipated, and date, if known? _____
P. Name(s) and address(es) of doctor(s) seen for this condition: _____

2. Chest Pain/Heart Attack/Abnormal Heart Beat/Heart Palpitations:

Person with condition: _____

Name of condition/diagnosis: _____

- A. Date of onset? _____
Cause, if known? _____
B. Name all tests performed, dates taken and results of each: _____
C. Type and date(s) of treatment? _____
D. Name medication(s) currently or previously taken: _____
E. Is medication being taken: [] on a continuous basis, or [] as needed? Frequency? _____

- F. Degree of recovery? _____
G. Any family history of heart and/or vascular disease?
If so, explain: _____
H. Do you: [] currently, or [] have you ever, used tobacco? If so, amount per day? _____
If not at present, date of last usage: _____
I. Type of future treatment and/or testing anticipated, and date, if known? _____
J. Name(s) and address(es) of doctor(s) seen for this condition: _____

3. Colitis/Irritable Bowel or Other Intestinal Disorders:

Person with condition: _____

Name of condition/diagnosis: _____

- A. If colitis, provide type (i.e., ulcerative, spastic, Crohn's):

- B. Date of onset? _____
- C. Number of attacks per year? _____
Date of last attack? _____
- D. Type and date(s) of treatment?

- E. Name of medication(s) currently or previously taken:

- F. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- G. If surgery was performed, type and date of surgery?

- H. Degree of recovery? _____
- I. Type of future treatment and/or testing anticipated, and date, if known? _____
- J. Name(s) and address(es) of doctor(s) seen for this condition: _____

4. Cyst/Polyp/Tumor:

Person with condition: _____

- A. Type? _____ How Many? _____
Exact Location? _____
- B. Is it still present? _____ Surgically removed? _____
- C. Benign or malignant? _____
- D. Type and dates of treatment? _____

- E. Describe follow-up treatment: _____

- F. Any recurrence? _____

- G. Results of follow-up: _____
- H. Degree of recovery? _____
- I. Type of future treatment and/or testing anticipated, and date, if known? _____

- J. Any family history of malignancy? _____ If so, explain:

- K. Name(s) and address(es) of doctor(s) seen for this condition: _____

5. Diabetes:

Person with condition: _____

- A. Date of onset? _____
- B. Is condition controlled by diet, oral medication or insulin?

- C. Provide your two most recent fasting blood sugar levels and the dates taken: _____

- D. Name and dosage of oral medication?

- E. Total number of units of insulin taken per day? _____
- F. Ever hospitalized for this condition? _____ If so, reason and dates? _____

- G. Any complications resulting from diabetes (i.e., poor circulation, retinopathy, etc.)? _____

- H. Any family history of diabetes and/or complications? _____ If so, explain: _____

- I. Type of future treatment and/or testing anticipated, and date, if known? _____

- J. Do you: currently, or have you ever, used tobacco? If so, amount per day? _____
If not at present, date of last usage: _____
- K. How often do you visit your doctor for your diabetes?

- L. Name(s) and address(es) of doctor(s) seen for this condition: _____

6. Diverticulitis/Diverticulosis (circle one):

Person with condition: _____

- A. Date of onset? _____ Location? (colon, esophagus, etc.) _____
- B. Type and date(s) of treatment? _____

- C. Number of attacks? _____
Date of last attack? _____
- D. If surgery was performed, type and date of surgery?

- E. Name medication(s) currently or previously taken:

- F. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- G. Type of future treatment and/or testing anticipated, and date, if known? _____

- H. Degree of recovery? _____
- I. Name(s) and address(es) of doctors(s) seen for this condition: _____

7. Epilepsy/Seizure Disorders:

Person with condition: _____

- A. Date of onset? _____
- B. Type of seizures (i.e., grand mal, petit mal, psychomotor, etc.)? _____
- C. Characteristics of seizure (i.e., loss of consciousness)?

- D. Frequency of seizures? _____
- E. Date of last seizure? _____
- F. Type and date(s) of treatment? _____

- G. Name medication(s) currently or previously taken:

- H. Ever hospitalized for this condition? _____ If so, when? _____
- I. Degree of recovery? _____
- J. Type of future treatment and/or testing anticipated, and date, if known? _____

- K. Name and address(es) of doctor(s) seen for this condition: _____

8. Eye/Ear Disorders:

Person with condition: _____

- A. Name of medical condition (diagnosis)?

- B. Condition affects: Eye – Left Right Both
 Ear – Left Right Both
- C. Date of onset? _____ Cause, if known? _____
- D. Type and date(s) of treatment?

- E. Date of last occurrence? _____
- F. Is condition controlled with medication? _____
- G. Name medication(s) currently or previously taken:

- H. If surgery was performed, type and date of surgery?
- I. If tubes were inserted, are they still present? _____ Which ear(s)? _____
- J. Describe visual/hearing impairment, if any:

- K. Degree of recovery? _____
- L. Type of future treatment and/or testing anticipated, and date, if known? _____

- M. For cataracts only: If removed from one eye, is the other eye free of opacity? _____
- N. Name(s) and address(es) of doctor(s) seen for this condition: _____

9. Reproductive Disorders/Hysterectomy:

Person with condition: _____

- A. Name of medical condition (diagnosis)?

- B. Date of onset? _____ Cause, if known? _____
- C. Describe symptoms: _____
- D. Type and date(s) of treatment?

- E. Name medication(s) currently or previously taken:

- F. If surgery was performed, provide type and date of surgery and indicate which organs were removed (e.g.,

uterus, tubes, ovaries): _____

- G. Any malignancy? _____
- H. Results of current pap smears and dates?

- I. Degree of recovery? _____
- J. Type of future treatment and or testing anticipated, and date, if known? _____

- K. Name(s) and address(es) of doctor(s) seen for this condition: _____

10. Gout:

Person with condition: _____

- A. Date of onset? _____
- B. Name medication(s) currently or previously taken:

- C. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- D. Number of attacks: _____ Dates and duration?

- E. Any history of high blood pressure or other cardiovascular or renal impairments? _____
- F. Current uric acid level? _____ Date taken? _____
- G. Type of future treatment and/or testing anticipated, and date, if known? _____
- H. Name(s) and address(es) of doctor(s) seen for this condition: _____

11. Heart Murmur/Mitral Valve Prolapse or Other Heart Valve Disorders:

Person with condition: _____

Name of condition/diagnosis: _____

A. Date of onset? _____

B. Cause or type of murmur and grade? (Obtain from doctor.) _____

C. Describe current symptoms: _____

D. Is murmur still present? _____

E. Describe restrictions in activity: _____

F. Type and date(s) of treatment? _____

G. Date of last visit to doctor for murmur? _____

H. Name medication(s) currently or previously taken: _____

I. Is medication(s) being taken: on a continuous basis, or as needed? Frequency? _____

J. Ever hospitalized for this condition? _____ If so, reason and dates? _____

K. Degree of recovery? _____

L. Type of future treatment and/or testing anticipated, and date, if known? _____

M. Any family history of heart and/or vascular disease? _____ If so, explain: _____

N. Do you: currently, or have you ever, used tobacco? If so, amount per day? _____

If not at present, date of last usage: _____

O. Name(s) and address(es) of doctor(s) seen for this condition: _____

12. Hernia:

Person with condition: _____

A. Type/location (i.e., hiatal, inguinal, umbilical, etc.)? _____

Date of onset: _____

B. Surgically corrected? Yes No If "Yes," provide date of surgery: _____

C. Type of future treatment and/or testing anticipated, and date, if known? _____

D. Name medication(s) currently or previously taken: _____

E. Is medication(s) being taken: on a continuous basis or, as needed? Frequency? _____

F. Describe current symptoms: _____

G. Number of attacks: _____
Date of last attack? _____

H. Degree of recovery? _____

I. Name(s) and address(es) of doctor(s) seen for this condition: _____

13. High Blood Pressure:

Person with condition: _____

A. Age at onset? _____ When did treatment begin? _____

B. Name medication(s) currently taking and dosage(s): _____

C. Have you had any change in medication? _____ If so, list name(s) of any past medications and dates prescribed: _____

D. How often do you visit your doctor for your blood pressure? _____

E. Ever hospitalized for this condition? _____ If so, reason and dates? _____

F. Have you ever experienced numbness or tingling in your hands or face, dizziness, headaches, loss of consciousness, rapid heart beat or palpitations? _____ If so, please explain and provide dates and treatment: _____

G. Any family history of heart and/or vascular disease? _____ If so, explain: _____

H. Provide your three most recent blood pressure readings from the last year to include at least one reading from the last 6 months (contact your doctor, if necessary)

READING	DATE
_____	_____
_____	_____
_____	_____

I. If you are not being treated currently or are not under a doctor's care for high blood pressure, provide a current blood pressure reading and date taken: _____

J. Do you: currently, or have you ever, used tobacco? If so, amount per day? _____

If not at present, date of last usage: _____

K. Name(s) and address(es) of doctor(s) seen for this condition: _____

14. Infertility (Male or Female)

Person with condition: _____

- A. Date of onset/diagnosis? _____
- B. Cause, if known? _____
- C. Has a physician been consulted? If so, provide date of initial consultation: _____
Frequency of consultations? _____
- D. Name medication(s) currently or previously taken: _____
- E. Type and dates of treatment? _____

- F. If surgery was performed, type and date of surgery? _____
- G. Was pregnancy achieved? _____ If so, were there any complications? _____
- H. Type of future treatment anticipated, and date, if known? _____
- I. Has a sterilization procedure been performed? _____
- J. Name(s) and address(es) of doctor(s) seen for this condition: _____

15. Kidney, Bladder, Prostate Disorders or Other Urinary System Disorders (i.e., Infection, Stone, Tumor, Obstruction):

Person with condition: _____

- A. Name of medical condition (diagnosis)? _____
- B. Date of onset? _____
Number of attacks per year? _____
Date of last attack? _____
- C. Type and date(s) of treatment? _____
- D. Name medication(s) currently or previously taken: _____
- E. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- F. Type and date of surgery, if any? _____
- G. Any current symptoms (i.e., nocturia, infections, tumor, obstruction)? _____

- H. For kidney infections, provide type (i.e., pyelonephritis, glomerulonephritis — If unknown, obtain from doctor): _____
- I. For kidney stones: one side both sides
Is/are stone(s) still present? _____
- J. For kidney disorders only: Any family history of congenital kidney disease? _____ If so, explain: _____
- K. Degree of recovery? _____
- L. Type of future treatment and/or testing anticipated, and date, if known? _____
- M. Name and address(es) of doctor(s) seen for this condition: _____

16. Mental/Nervous Disorders (i.e., Anxiety, Depression, etc.):

Person with condition: _____

- A. Name of medical condition (diagnosis)? _____
- B. Date of onset? _____
Cause, if known? _____
- C. Name medication(s) currently or previously taken: _____
- D. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- E. Frequency of counseling sessions? _____
- F. Ever hospitalized for this condition? _____ If so, reason and dates? _____

- G. Any time lost from work? _____ If so, duration? _____
- H. Current status of condition? _____
- I. Have you ever had any suicidal tendencies? _____
Have you ever attempted suicide? _____
If so, provide date(s): _____
- J. Type of future treatment and/or testing anticipated, and date, if known? _____
- K. Name and address(es) of doctor(s) seen for this condition: _____

17. Pregnancy or History of High Risk Pregnancy, Premature Delivery or Complications of Pregnancy:

Person with condition: _____

A. Pregnancy due date? _____

B. Was pregnancy confirmed by a doctor? _____
If not, how was it confirmed? _____

C. Results of amniocentesis and/or ultrasounds?

D. Any (including family) history of: prematurity (less than 37 weeks gestation), postmaturity (greater than 42 weeks), birth defects (e.g. Down's Syndrome, spina bifida, etc.), complications during pregnancy (C-Section, stillbirth, bleeding, preeclampsia [high blood pressure with edema and/or protein in urine], eclampsia [convulsions, etc.], abortions, miscarriages, RH problems, multiple births, placenta previa or abruptio, diabetes, heart, kidney or viral disease, ectopic pregnancy, etc.)?
EXPLAIN: _____

E. If "Yes" to "D" above, and if applicable, how long was baby confined in the hospital? _____

F. If currently pregnant, do you drink alcohol? _____
Amount? _____

G. Do you take any drugs and/or work in an environment with possible toxic chemicals or fumes exposure?

If "Yes," explain: _____

H. Are you now, or have you ever, taken fertility drugs?
_____ If "Yes," explain: _____

I. Has a sterilization procedure been performed or is a sterilization procedure anticipated? _____
If so, when? _____

J. Type of future treatment and/or testing anticipated, if known? _____

K. Name(s) and address(es) of doctor(s) seen for this condition: _____

18. Respiratory Disorders, i.e., Asthma, Bronchitis, etc.:

Person with condition: _____

A. Name of medical condition (diagnosis)?

B. Date of onset? _____ Number of attacks per year? _____
Date of last attack? _____

C. Name medication(s) currently or previously taken:

D. Is medication being taken: on a continuous basis, or as needed? Frequency? _____

E. Ever hospitalized for this condition? _____ If so, reason and dates? _____

F. Any time lost from work? _____ If so, duration? _____

G. Do you: currently, or have you ever, used tobacco? If so, amount per day? _____
If not at present, date of last usage: _____

H. Degree of recovery: _____

I. Type of future treatment and/or testing anticipated, and date, if known? _____

J. Name and address(es) of doctor(s) seen for this condition: _____

19. Thyroid Disorders:

Person with condition: _____

A. Overactive (hyperthyroidism) Date of onset: _____
 Underactive (hypothyroidism)

B. Is a growth/goiter present? _____ History of malignancy? _____

C. Controlled with medication? _____

D. Name medication(s) currently or previously taken:

E. Type and date(s) of treatment?

F. Ever hospitalized for this condition? _____

G. If surgery was performed, type and date of surgery?

H. Degree of recovery: _____

I. Type of future treatment and/or testing anticipated, and date, if known? _____

J. Any family history of thyroid disease and/or malignancy? _____ If so, explain: _____

K. Name and address(es) of doctor(s) seen for this condition: _____

20. Ulcer/Esophageal Disorders/Stomach Disorders:

Person with condition: _____

- A. Name of medical condition/diagnosis: _____
- B. If ulcer, type (i.e., duodenal, gastric, etc.)? _____
- C. Date of onset? _____
- D. Was it confirmed by an x-ray or other diagnostic testing? _____
- E. Number and dates of attacks? _____
- F. Any history of bleeding? _____ When? _____
- G. Name medication(s) currently or previously taken: _____

- H. Is medication being taken: on a continuous basis, or as needed? Frequency? _____
- I. If surgery was performed, type and date of surgery? _____
- J. Degree of recovery? _____
- K. Type of future treatment and/or testing anticipated, and date, if known? _____
- L. Do you: currently, or have you ever, used tobacco? If so, amount per day? _____
If not at present, date of last usage: _____
- M. Name(s) and address(es) of doctor(s) seen for this condition: _____

21. Other Conditions (Provide information from the past five years only):

Person with condition: _____

- A. Diagnosis? _____
- B. Date of onset? _____
- C. Type and dates of treatment? _____
- D. Name medications currently or previously taken: _____

- E. Degree of recovery? _____
- F. Type of future treatment and/or testing anticipated, and date, if known? _____
- G. Name(s) and address(es) of doctor(s) seen for this condition? _____

BY SIGNING BELOW, I HEREBY REPRESENT THAT ALL OF THE HEALTH HISTORY STATEMENTS/ANSWERS PROVIDED TO QUESTIONS 1 THROUGH 21 ARE TRUE AND ACCURATE AND I AGREE THAT THEY SHALL BECOME A PART OF THE APPLICATION DATED _____.

MONTH/DAY/YEAR

NOTICE: For Florida residents only: We are required by Florida law to inform you of the following: “Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.”

NOTICE: For New Mexico residents only: We are required by New Mexico law to inform you of the following: “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.

NOTICE: For Kentucky and Ohio residents only: We are required by Kentucky and Ohio law to inform you of the following: “Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

NOTICE: For Pennsylvania residents only: We are required by Pennsylvania law to inform you of the following: “Any person who knowingly and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

Signature of Applicant	Date
Signature of Spouse (if applicable)	Date



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