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**

_____

_____

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

_____

_____

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

_____

_____

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

_____

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

_____

_____

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

_____

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**

_____

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

_____

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

Signature: _____ Date: _____