UNIFI
Companies

Application for Insurance

Health Questionnaire

Ameritas Life Insurance Corp. of New York
P.O. Box 40888, Cincinnati, OH 45240
877-280-6110, Fax 513-595-2352
(Client Service Office)

The Union Central Life Insurance Company
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Name of Proposed Insured:_____

Health Questions. Please provide Details for "Yes" answers.

1. a) Height: _____ b) Weight: _____
   c) Have you lost 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
   d) Have you gained 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
2. To the best of your knowledge and belief, have you ever been medically treated for or had any known indication of:
   a) Disorder of eyes, ears, nose, or throat? ☐ Yes ☐ No
   b) Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, paralysis, or stroke? ☐ Yes ☐ No
   c) Shortness of breath, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d) Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e) Jaundice, intestinal bleeding; ulcer, hernia, colitis, hepatitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? ☐ Yes ☐ No
   f) Sugar, albumin, blood or pus in urine; sexually transmitted disease; stone or other disorder of kidney or bladder? ☐ Yes ☐ No
   g) Diabetes, thyroid, or other endocrine disorders? ☐ Yes ☐ No
   h) Disorder of the breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   i) Neuritis, arthritis, rheumatism, gout, or disorder of or injury to the bones, muscles, nerves, knees, wrists or other joints? ☐ Yes ☐ No
   j) Disorder of the skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   k) Allergies; anemia or other disorder of the blood, excluding AIDS, or HIV? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Anxiety, depression, stress, or other mental, nervous, psychiatric or emotional disorder? ☐ Yes ☐ No
   n) Chronic fatigue, fibromyalgia, or Epstein-Barr virus? ☐ Yes ☐ No
   o) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   p) Any mental or physical disorder not listed above? ☐ Yes ☐ No
3. Have you ever consulted a chiropractor? ☐ Yes ☐ No
4. Are you currently pregnant? ☐ Yes ☐ No
5. Other than noted above, have you within the past five years:
   a) Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had an electrocardiogram, X-ray, or other diagnostic test, other than an HIV test? ☐ Yes ☐ No
   b) Been advised by a licensed medical professional to have any diagnostic test, other than an HIV test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
6. Within the past ten years, have you ever:
   a) Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b) Sought or received medical treatment or professional advice for the use of alcohol, cocaine, marijuana, narcotics or any other drug? ☐ Yes ☐ No
   c) Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
7. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
8. Have any of your immediate family members (parents, brothers, and sisters), died of or been diagnosed as having; coronary artery disease, diabetes, cancer, stroke or kidney disease, prior to age 60? ☐ Yes ☐ No

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters			

9. a) Name and address of personal or attending doctor:
   _____
   _____
   _____
   b) Telephone:
   c) Date last consulted:
   Reason and any medication/treatment given:
   _____
   d) List any medications *(prescription or nonprescription)* you are taking currently:
   _____
   _____

For each "Yes" answer, give details. *(Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional Health Questionnaire page, UN 2550 HQ NY, or additional sheet of paper, if needed.)*