FERNEDING INSURANCE HEALTH HISTORY QUESTIONNNAIRE

Contact Name:____

Home Address:____

City:___________________________________ State:_____________ Zip: ___________________

Home Phone:____________________________ Work Phone:________________________________

Cell Phone: _____________________________ Fax Phone: ________________________________

Email: _________________________________ Best time to contact: ________________________

Applicant:

Name: ____ Sex: ___________________

Date of Birth: ______/______/______ Height: ______feet ____inches Weight:______ pounds
Tobacco use: none [ ] cigarettes [ ] (number per day______) Other [ ] Explain:
Occupation: (please describe your duties)____

Other than regular "check ups" have you visited a physician, clinic or hospital for any reason in the last five years? Yes [ ] No [ ]
If "Yes" please give details and dates.

Medications currently taking:

Medication	Dosage	Frequency	Diagnosis	Onset

Do you have any ongoing health issues? Explain

DISABILITY QUESTIONS:

Annual Income: $__________________ Number of years experience on your job: _________

Waiting Period desired (days) 30[ ] 60[ ] 90[ ] 180[ ] 360[ ]

Duration of benefits: 24 months [ ] 60 months [ ] to age 65+ [ ]

Amount of monthly benefit desired: $________________________

Will employer pay premium: no[ ] yes[ ] if yes, explain tax consequence

Any other coverage: no[ ] yes[ ] Explain: _______________________________________