

Home Office Use Only

APP DEC W/D PP

UND

Date

♦ **GENERAL INFORMATION**

Medical #: _____ Policy #: _____ Agency: _____
 Name of Insured: _____ Address: _____
 Date of Birth: _____ Occupation: _____ Height: _____ Weight: _____
 Do you currently use any tobacco products? Yes No
 Have you smoked any cigarettes or used any tobacco products in the past and quit? Yes No
 If "Yes", When did you quit? _____
 Month /Day/ Year
 Did you quit at the recommendation of a physician because of a medical condition? Yes No
 If "Yes", give the medical condition, etc. _____

**For policies rate due to occupation, a letter of explanation from the applicant must accompany this form.
 For policies rated due to aviation or avocation, the appropriate questionnaire must accompany this form.**

♦ **MEDICAL INFORMATION**

Answer the following questions "Yes or No":
 Since making application for the above-numbered policy, to the best of your knowledge and belief, have you had, been told that you had, been treated for or had surgery for:
(Please circle any condition answered "Yes" and give details in the space to the right. Include name, address and phone for physicians, hospitals, etc.)

a. Heart, blood vessels, chest pain, palpitation, heart murmur, heart attack, shortness of breath, high blood pressure? Yes No _____
 b. Lungs, tuberculosis, asthma, bronchitis or emphysema? Yes No _____
 c. Albumin, blood or sugar in urine, diabetes, kidney or reproductive organs? Yes No _____
 d. Mental, emotional or nervous system disorder, epilepsy, stroke or any disorder of the brain? Yes No _____
 e. Anemia or blood disorder? Yes No _____
 f. Cancer or other tumor? Yes No _____
 g. Thyroid, gout, arthritis, muscles, bones or joints? Yes No _____
 h. Ulcers, rectal bleeding or digestive system (stomach, intestines, liver, gall bladder or pancreas)? Yes No _____
 i. Any physical deformity or surgical operation? Yes No _____
 j. Alcoholism, alcohol abuse or addiction? Yes No _____
 k. Ever used heroin, narcotics, cocaine or any drugs except as prescribed by a physician? Yes No _____
 l. AIDS or AIDS related conditions? Yes No _____
 m. Are you now under observation or taking treatment? Yes No _____

NAME AND ADDRESS OF PHYSICIAN	DATE LAST SEEN	REASON AND TREATMENT GIVEN

♦ AUTHORIZATION TO RELEASE INFORMATION

I authorize the following persons and/or institutions that have any records or knowledge of me or my minor children, my employment, and my or my minor child's health to give any such information to Vantis Life or its reinsurers: any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person. I understand that the information released to Vantis Life or its reinsurers will be used to determine my eligibility for the insurance requested. Vantis Life may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of Vantis Life. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any information relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photo copies of it will be valid for two and one half years following the date signed, unless otherwise required by law. The information released to Vantis Life will not be given, sold or transferred to any other person not mentioned above.

I acknowledge that I have read the IMPORTANT NOTICE and I understand that I am entitled to a photocopy of this authorization upon request. I hereby acknowledge receipt of the notice to applicant.

X

Legal Signature of Insured

Date

Medical Information Bureau: Information you provide will be treated as confidential except that Vantis Life Insurance Company may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Vantis Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office: Post Office Box 105, Essex Station, Boston, MA 02112; telephone: 617-426-3660.

Fair Credit Reporting Act: As part of our normal procedure, an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members, business associates, friends, financial sources, neighbors or others with whom you are acquainted. Such an inquiry typically may include information as to character, general reputation, personal characteristics and mode of living of the person to be insured. You have the right under the law to receive on your written request, disclosures of the nature and scope of any investigative consumer report.

Supplementary Notice of Information Practices: Vantis Life may need to obtain data about you prior to issuance of insurance. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent. You have the right of access and correction to data to data received about you, but data about a civil or criminal proceeding is excepted. If you would like a more detailed explanation of our information practices, please contact: Underwriting Department, Vantis Life insurance Company, 200 Day Hill Road, Windsor, CT 06095.



AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR INSURANCE

Name of Insured: _____ Date of Birth: _____

Address: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Vantis Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (*HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Vantis Life may:

- 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
- 4) administer coverage; and
- 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Vantis Life.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Vantis Life Insurance Company at 200 Day Hill Road Windsor, CT 06095 Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that Vantis Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Vantis Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

Print Name of Individual or Authorized Representative

Date Signed

COMPLETE IN DUPLICATE AND RETAIN A COPY FOR YOUR RECORDS