

GeoCare Special Group Insurance Program

RUTHERFOORD INTERNATIONAL

QUESTIONNAIRE FOR LIFE, AD&D, LTD

Name of principal to be insured: _____

Name of applicant: _____

1. Give complete details to any "yes" answers in the space provided, or attached to this form, including name of family member, condition treated, care received, dates treatment started and ended, current status, doctor's name and address

Conditions	Yes	No	Conditions	Yes	No
Brain or nervous system			Muscular and skeleton system		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Back, spine or neck disorder	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Deformity or loss of limb	<input type="checkbox"/>	<input type="checkbox"/>
Strokes or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Muscle disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other brain disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism or rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Digestive system			Skin		
Chronic indigestion or diarrhea, colitis,	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease or disorder including	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disorder, gallstone	<input type="checkbox"/>	<input type="checkbox"/>	dermatitis, eczema, edema, burns,	<input type="checkbox"/>	<input type="checkbox"/>
Hernias, hemorrhoids, fistula, fissure	<input type="checkbox"/>	<input type="checkbox"/>	herpes, psoriasis, shingles, ...	<input type="checkbox"/>	<input type="checkbox"/>
Liver or pancreas problem	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive organ		
Stomach, intestine, esophagus or anal	<input type="checkbox"/>	<input type="checkbox"/>	Breast disease	<input type="checkbox"/>	<input type="checkbox"/>
canal disorder or ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Complications of pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Glands and endocrine system			Infertility and sterility	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Prostate disease or problem	<input type="checkbox"/>	<input type="checkbox"/>
Goiter and/or enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Uterine or menstrual disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or hypophysis disorder	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory system		
Heart and vascular system			Asthma, allergies, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder including anemia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pneumonia, cough, bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure including controlled	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath, emphysema	<input type="checkbox"/>	<input type="checkbox"/>
pressure and medication taken	<input type="checkbox"/>	<input type="checkbox"/>	Throat or respiratory tract disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular, fast or slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis, spitting of blood	<input type="checkbox"/>	<input type="checkbox"/>
Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	Urinary system		
Phlebitis, varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Albumin, sugar or pus in urine	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Other vascular or heart disorder or	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
problem	<input type="checkbox"/>	<input type="checkbox"/>	Infection of the genitourinary tract	<input type="checkbox"/>	<input type="checkbox"/>
Immune system			Kidney disorder or kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Acquired immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions		
syndrome (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
ARC (AIDS-related complex)	<input type="checkbox"/>	<input type="checkbox"/>	Burn-out	<input type="checkbox"/>	<input type="checkbox"/>
Human immunodeficiency Virus (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	Cysts, moles, warts, polyps, growths	<input type="checkbox"/>	<input type="checkbox"/>
Kaposi's sarcoma	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse or addiction	<input type="checkbox"/>	<input type="checkbox"/>
Mental or neurological system			Ear or hearing disorder or impairment	<input type="checkbox"/>	<input type="checkbox"/>
Impairment of speech	<input type="checkbox"/>	<input type="checkbox"/>	Eye or sight disorder or impairment	<input type="checkbox"/>	<input type="checkbox"/>
Mental or emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	Malaria and/or any bacterial infection	<input type="checkbox"/>	<input type="checkbox"/>
Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Nose or throat disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>

Complete details (if more space required, use a separate sheet):

applicant's signature _____ date signed _____

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Name of principal to be insured: _____

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- 2 In addition to the questions shown on the preceding page, have you ever been diagnosed or treated for any:
- | | | |
|--|------------------------------|-----------------------------|
| Chronic or recurring illness? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Birth or congenital defect, disease or disorder? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Type of cancer, tumor or metastasis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Illness or injury not mentioned? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Condition requiring an operation or special diagnostic test? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
3. Within the past 5 years, have you had any loss of weight, been hospitalized, in a sanatorium, or other institution for observation or treatment, had any diagnostic tests or studies, have reason to believe you need or have been advised to have surgery or medical or psychological treatment, consulted any doctors, therapists, counselors or healthcare providers of any kind, received any treatment or taken any prescription medicine regularly or at frequent intervals? yes no
4. Are you currently taking prescribed medication, under medical treatment or pregnant? yes no
5. Have you been absent from work due to sickness or accident for a period in excess of one week? yes no
6. Has any application for Life, Accident and Health insurance, or reinstatement of such insurance in your name ever been declined, postponed, rated or in any way modified? yes no

Complete details:

applicant's signature _____ date signed _____