

SERFF Tracking Number: UNAM-125554567 State: Arkansas  
Filing Company: Pennsylvania Life Insurance Company State Tracking Number: 38470  
Company Tracking Number: MCF-398(08)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Request for Life Insurance Policy Change  
Project Name/Number: Multi Purpose Form/MCF-398(08)

## Filing at a Glance

Company: Pennsylvania Life Insurance Company

Product Name: Request for Life Insurance SERFF Tr Num: UNAM-125554567 State: ArkansasLH

Policy Change

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 38470

Sub-TOI: L08.000 Life - Other

Co Tr Num: MCF-398(08)

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Laura Hoogland

Disposition Date: 04/01/2008

Date Submitted: 03/20/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Multi Purpose Form

Status of Filing in Domicile: Pending

Project Number: MCF-398(08)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This form is simultaneously being submitted to Pennsylvania, the state in which we are domiciled.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/01/2008

State Status Changed: 04/01/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This Request for Life Insurance Policy Change will be used to service in-force, approved life policies. Section I through X will be used for changes that may not require evidence of insurability. If evidence of insurability is required, there is a notation in that section to complete the Evidence of Insurability section of this form. If the Evidence of Insurability is required, the applicant will also be required to sign and authorize on page 4 of this form.

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## Company and Contact

### Filing Contact Information

Laura Hoogland, lhoogland@uafc.com  
 8001 Broadway (219) 736-7700 [Phone]  
 Merrillville, IN 46410

### Filing Company Information

Pennsylvania Life Insurance Company CoCode: 67660 State of Domicile: Pennsylvania  
 1001 Heathrow Park Lane Group Code: 953 Company Type:  
 Suite 5001  
 Lake Mary, FL 32746 Group Name: State ID Number:  
 (407) 995-8000 ext. [Phone] FEIN Number: 23-1305366  
 -----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pennsylvania Life Insurance Company	\$20.00	03/20/2008	18827744

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/01/2008	04/01/2008

SERFF Tracking Number: UNAM-125554567 State: Arkansas  
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## Disposition

Disposition Date: 04/01/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UNAM-125554567 State: Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		Yes
<b>Form</b>	Request for Life Insurance Policy Change		Yes

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## Form Schedule

**Lead Form Number:** MCF-398(08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MCF-398(08)	Application/ Enrollment Form	Request for Life Insurance Policy Change	Initial		50	MCF-398(08).pdf



PENNSYLVANIA LIFE INSURANCE CO.

P.O. Box 958465
Lake Mary, Florida 32795-8465
("THE COMPANY")

REQUEST FOR LIFE INSURANCE POLICY CHANGE

NAME OF INSURED: POLICY NUMBER:
Insured's Social Security Number (if Insured is other than Owner)
Owner's Social Security Number
Address of the Insured
Address of Owner (if other than Insured)

I. REISSUE (Complete the Evidence of Insurability section on pages 2 and 3.)

Form I: REISSUE. Includes fields for Change Plan of Insurance (Original Date, New Plan, Other), Correct Date of Birth, Increase Face Amount, and Reduce Face Amount.

II. CONVERSION OF TERM POLICY OR RIDER

(If supplemental benefits are applied for, complete the Evidence of Insurability section on pages 2 and 3.)

Conversion Amount Plan Anniversary Date Supplemental Benefits Desired If Converting to Universal Life:

Form II: CONVERSION OF TERM POLICY OR RIDER. Includes checkboxes for Waiver of Premium, Accidental Death, Other, Cash Value Type A/B, and Mode of Premium Payment (Annual, Semiannual, Check-O-Matic).

III. REINSTATEMENT (Complete the Evidence of Insurability section on pages 2 and 3.)

Form III: REINSTATEMENT. Includes checkboxes for Lapsed Policy, Extended Insurance, Reduced Paid-Up, Premium Amount Submitted, and Mode.

IV. UNIVERSAL LIFE CASH VALUE CHANGE

V. DESIGNATED OR SPECIFIED AMOUNT

Form IV and V: UNIVERSAL LIFE CASH VALUE CHANGE and DESIGNATED OR SPECIFIED AMOUNT. Includes checkboxes for Include/Exclude from Designated or Specified Amount, Increase/Decrease By, and a note to complete Evidence of Insurability section.

VI. ADDITION/DELETION OF BENEFITS (Complete the Evidence of Insurability section on pages 2 and 3 for addition of benefits.)

Form VI: ADDITION/DELETION OF BENEFITS. Includes checkboxes for Addition of Benefits (Waiver of Premium, Accidental Death, Other) and Deletion of Benefits (Waiver of Premium, Accidental Death, Other).

VII. CHANGE TO NONSMOKER RATES Please complete question #4 on page 3 and sign page 4.

**VIII. PLANNED PERIODIC PREMIUM CHANGE**

<input type="checkbox"/> Bill for \$ _____ as of _____	<input type="checkbox"/> Draft for \$ _____ as of _____
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**IX. SINGLE PREMIUM POLICY**

<input type="checkbox"/> Change to Single Premium Policy	Apply \$ _____ Premium Attached
--	---------------------------------

**X. REMARKS**

**EVIDENCE OF INSURABILITY**

**A. OCCUPATION:** List Employer's Name, Address, Phone No., Duties, and Annual Income

	Duties	Annual Income
Primary Insured _____	_____	_____
Spouse _____	_____	_____
Other Insured _____	_____	_____

**B. OTHER INSURANCE IN FORCE:** (List Life Insurance in Force) If no insurance, check here

Company Name and Location	Name of Insured	Amount	ADB	Year Issued

Does the applicant own existing, in-force policies or contracts on the same insured?  Yes  No  
 (If "yes", complete required replacement form.)

**C. HEIGHT AND WEIGHT INFORMATION:**

	Height	Weight	Any weight change in the past year?
Primary Insured _____	_____	_____	_____
Spouse _____	_____	_____	_____
Other Insured _____	_____	_____	_____
Children _____	_____	_____	_____
(list names) _____	_____	_____	_____
_____	_____	_____	_____

**D. EVIDENCE OF INSURABILITY:** To be completed by all applicants.

Each Person to be Insured							
Primary Insured		Spouse		Dependents		Other Insureds	
Yes	No	Yes	No	Yes	No	Yes	No
<b>1. HAS PERSON PROPOSED FOR INSURANCE:</b>							
a) Had an application for life or health insurance or reinstatement declined, rated or modified in any way? . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been convicted within the last 3 years for a moving violation, or of driving while under the influence, or had a driver's license suspended or revoked? (If yes, give driver's license No., and state in remarks section) . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you currently, or in the last 12 months, have you been: hospitalized, confined to a nursing home or receiving home health care? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. WITHIN THE PAST 10 YEARS HAS ANY PERSON BEEN ADVISED, DIAGNOSED OR ADVISED TO RECEIVE TREATMENT BY A PHYSICIAN FOR:</b>							
a) Alzheimer's, Dementia, Stroke, TIA (Trans-ischemic attack), Congestive Heart Failure, Emphysema or other disorder of the lungs, cancer or tumor, Leukemia, Lymphoma, Diabetes requiring insulin, Kidney disease, Cirrhosis of the liver, or Hepatitis C? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Acquired Immune Deficiency Syndrome (AIDS), or an immune deficiency related disorder or had a positive blood test indicating exposure to HIV? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. WITHIN THE PAST FIVE YEARS HAS PERSON PROPOSED FOR INSURANCE:</b>							
a) Consulted, been examined or treated by any physician or medical professional, or been admitted to or treated at a hospital or other facility for any disease or condition not indicated above? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Had an x-ray, EKG or any laboratory test or study, or been advised to have a surgical operation? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been treated for alcoholism or substance (drug) abuse, or been a regular or frequent user of cocaine or narcotics not prescribed by a physician? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. HAS PERSON PROPOSED FOR INSURANCE USED TOBACCO IN THE PAST 12 MONTHS? (If yes, indicate name, frequency and type) . . . . .</b>							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. DETAILS:**

**IF ANY PART OF QUESTIONS 1 THROUGH 4 ARE ANSWERED YES, GIVE DETAILS BELOW:**

Ques. No.	Person Affected	Date	Nature of each injury, illness or consultation	Describe treatment or surgery performed	Date of recovery	Name and address Doctor and/or hospitals



<i>SERFF Tracking Number:</i>	<i>UNAM-125554567</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pennsylvania Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38470</i>
<i>Company Tracking Number:</i>	<i>MCF-398(08)</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Request for Life Insurance Policy Change</i>		
<i>Project Name/Number:</i>	<i>Multi Purpose Form/MCF-398(08)</i>		

## **Rate Information**

Rate data does NOT apply to filing.

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Product Name: Request for Life Insurance Policy Change  
Project Name/Number: Multi Purpose Form/MCF-398(08)

## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Certification/Notice 03/18/2008  
**Comments:**  
**Attachment:**  
ARSubltr.pdf

**Review Status:**  
**Satisfied -Name:** Application 03/18/2008  
**Comments:**  
**Attachment:**  
MCF-398 (08).pdf

# PENNSYLVANIA LIFE INSURANCE COMPANY

1001 Heathrow Park Lane, Suite 5001  
Lake Mary, FL 32746  
800 275 6667 toll-free  
407 995 8007 phone  
407 995 8047 fax  
www.pennlife.com

March 19, 2008

Arkansas Insurance Department  
Policy Form Filing  
1200 West Third Street  
Little Rock, Arkansas, 72201-1904

Re: NAIC #67660  
FEIN: 23-1305366  
**New Submission – Life Form**  
Request for Life Insurance Policy Change – Form No. MCF-398(08)

To Whom It May Concern:

We are submitting the above referenced form to you for your review and approval. This form is new and never been used by Pennsylvania Life Insurance Company. This form will replace our Request for Life Insurance Policy Change, form no. MCF-398 Ed. 1-94 which was previously approved for use in your state on March 7, 1994.

This form is simultaneously being submitted for approval to the state of Pennsylvania, the state in which we are domiciled.

The differences in this form from the one previously approved are as follows:

- The format of this form is single side and on letter size paper, while the previously approved form was on legal paper and printed front and back.
- The authorization section has been updated to comply with more current laws and regulations.

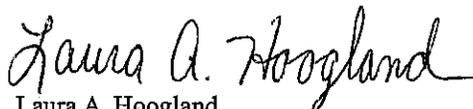
This Request for Life Insurance Policy Change, form no. MCF-398(08) will be used to service in-force, approved life policies. Sections I. through X. will be used for changes that may not require evidence of insurability. If evidence of insurability is required, there is a notation in that section to complete the Evidence of Insurability section of this form. If the Evidence of Insurability is required the applicant will also be required to sign and authorize on page 4 of this form.

We certify that this form complies with the provisions of 19 ss 10B and all applicable requirements of the Department. We also certify that both the Life and Health Guaranty Association Notice and agent contact information will be delivered with the policy in compliance with Regulation 49 and Arkansas Insurance Code 23-79-138.

I look forward to your review and approval of this form. If you have any questions or concerns, please feel free to contact me. I can be reached by telephone at 1-800-577-1857, ext. 111, or by e-mail to [Lhoogland@uafc.com](mailto:Lhoogland@uafc.com). You may also send a fax to 1-219-736-6059.

Thank you for your time and consideration in this matter.

Sincerely,



Laura A. Hoogland  
Sr. Contract Analyst



PENNSYLVANIA LIFE INSURANCE CO.

P.O. Box 958465
Lake Mary, Florida 32795-8465
("THE COMPANY")

REQUEST FOR LIFE INSURANCE POLICY CHANGE

NAME OF INSURED: POLICY NUMBER:
Insured's Social Security Number (if Insured is other than Owner)
Owner's Social Security Number
Address of the Insured
Address of Owner (if other than Insured)

I. REISSUE (Complete the Evidence of Insurability section on pages 2 and 3.)

Form I: REISSUE. Includes fields for Change Plan of Insurance (Original Date, New Plan, Other), Correct Date of Birth, Increase Face Amount, and Reduce Face Amount.

II. CONVERSION OF TERM POLICY OR RIDER

(If supplemental benefits are applied for, complete the Evidence of Insurability section on pages 2 and 3.)

Conversion Amount Plan Anniversary Date Supplemental Benefits Desired If Converting to Universal Life:

Form II: CONVERSION OF TERM POLICY OR RIDER. Includes checkboxes for Waiver of Premium, Accidental Death, Other, Cash Value Type A/B, and Mode of Premium Payment (Annual, Semiannual, Check-O-Matic).

III. REINSTATEMENT (Complete the Evidence of Insurability section on pages 2 and 3.)

Form III: REINSTATEMENT. Includes checkboxes for Lapsed Policy, Extended Insurance, Reduced Paid-Up, Premium Amount Submitted, and Mode.

IV. UNIVERSAL LIFE CASH VALUE CHANGE

V. DESIGNATED OR SPECIFIED AMOUNT

Form IV and V: UNIVERSAL LIFE CASH VALUE CHANGE and DESIGNATED OR SPECIFIED AMOUNT. Includes checkboxes for A) Include, B) Exclude, Increase/Decrease By, and instructions to complete Evidence of Insurability section.

VI. ADDITION/DELETION OF BENEFITS (Complete the Evidence of Insurability section on pages 2 and 3 for addition of benefits.)

Form VI: ADDITION/DELETION OF BENEFITS. Includes checkboxes for Addition of Benefits (Waiver of Premium, Accidental Death, Other) and Deletion of Benefits (Waiver of Premium, Accidental Death, Other).

VII. CHANGE TO NONSMOKER RATES Please complete question #4 on page 3 and sign page 4.

VIII. **PLANNED PERIODIC PREMIUM CHANGE**

<input type="checkbox"/> Bill for \$ _____ as of _____	<input type="checkbox"/> Draft for \$ _____ as of _____
--	---

IX. **SINGLE PREMIUM POLICY**

<input type="checkbox"/> Change to Single Premium Policy	Apply \$ _____ Premium Attached
--	---------------------------------

X. **REMARKS**

**EVIDENCE OF INSURABILITY**

A. **OCCUPATION:** List Employer's Name, Address, Phone No., Duties, and Annual Income

	Duties	Annual Income
Primary Insured _____	_____	_____
Spouse _____	_____	_____
Other Insured _____	_____	_____

B. **OTHER INSURANCE IN FORCE:** (List Life Insurance in Force) If no insurance, check here

Company Name and Location	Name of Insured	Amount	ADB	Year Issued

Does the applicant own existing, in-force policies or contracts on the same insured?  Yes  No  
 (If "yes", complete required replacement form.)

C. **HEIGHT AND WEIGHT INFORMATION:**

	Height	Weight	Any weight change in the past year?
Primary Insured _____	_____	_____	_____
Spouse _____	_____	_____	_____
Other Insured _____	_____	_____	_____
Children _____	_____	_____	_____
(list names) _____	_____	_____	_____
_____	_____	_____	_____

**D. EVIDENCE OF INSURABILITY:** To be completed by all applicants.

Each Person to be Insured							
Primary Insured		Spouse		Dependents		Other Insureds	
Yes	No	Yes	No	Yes	No	Yes	No
<b>1. HAS PERSON PROPOSED FOR INSURANCE:</b>							
a) Had an application for life or health insurance or reinstatement declined, rated or modified in any way? . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been convicted within the last 3 years for a moving violation, or of driving while under the influence, or had a driver's license suspended or revoked? (If yes, give driver's license No., and state in remarks section) . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you currently, or in the last 12 months, have you been: hospitalized, confined to a nursing home or receiving home health care? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. WITHIN THE PAST 10 YEARS HAS ANY PERSON BEEN ADVISED, DIAGNOSED OR ADVISED TO RECEIVE TREATMENT BY A PHYSICIAN FOR:</b>							
a) Alzheimer's, Dementia, Stroke, TIA (Trans-ischemic attack), Congestive Heart Failure, Emphysema or other disorder of the lungs, cancer or tumor, Leukemia, Lymphoma, Diabetes requiring insulin, Kidney disease, Cirrhosis of the liver, or Hepatitis C? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Acquired Immune Deficiency Syndrome (AIDS), or an immune deficiency related disorder or had a positive blood test indicating exposure to HIV? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. WITHIN THE PAST FIVE YEARS HAS PERSON PROPOSED FOR INSURANCE:</b>							
a) Consulted, been examined or treated by any physician or medical professional, or been admitted to or treated at a hospital or other facility for any disease or condition not indicated above? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Had an x-ray, EKG or any laboratory test or study, or been advised to have a surgical operation? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been treated for alcoholism or substance (drug) abuse, or been a regular or frequent user of cocaine or narcotics not prescribed by a physician? . . . . .							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. HAS PERSON PROPOSED FOR INSURANCE USED TOBACCO IN THE PAST 12 MONTHS? (If yes, indicate name, frequency and type) . . . . .</b>							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. DETAILS:**

**IF ANY PART OF QUESTIONS 1 THROUGH 4 ARE ANSWERED YES, GIVE DETAILS BELOW:**

Ques. No.	Person Affected	Date	Nature of each injury, illness or consultation	Describe treatment or surgery performed	Date of recovery	Name and address Doctor and/or hospitals

