

SERFF Tracking Number: METD-126382418 State: Arkansas  
Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
Company Tracking Number: EWEB-67-10  
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Application for Life Insurance  
Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

## Filing at a Glance

Company: MetLife Investors USA Insurance Company

Product Name: Application for Life Insurance SERFF Tr Num: METD-126382418 State: Arkansas  
TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 44831  
Closed

Sub-TOI: L04I.103 Renewable - Single Life - Co Tr Num: EWEB-67-10 State Status: Approved-Closed  
Fixed/Indeterminate Premium  
Filing Type: Form

Reviewer(s): Linda Bird  
Authors: Patricia Crowley, Karen Disposition Date: 04/08/2010  
Poor  
Date Submitted: 02/12/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested:  
State Filing Description:

Implementation Date:

## General Information

Project Name: Internet Term Life Insurance Application  
Project Number: EWEB-67-10  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 04/08/2010

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Explanation for Other Group Market Type:  
State Status Changed: 02/17/2010  
Created By: Patricia Crowley  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Patricia Crowley  
Filing Description:  
RE: MetLife Investors USA Insurance Company  
NAIC #241-61050 FEIN #54-0696644  
Individual Life Application Form Filing  
Forms: EWEB-67-10 Application for Life Insurance  
TPROD-68-10 Term Product Supplement  
State of Domicile: Delaware



<i>SERFF Tracking Number:</i>	<i>METD-126382418</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>MetLife Investors USA Insurance Company</i>	<i>State Tracking Number:</i>	<i>44831</i>
<i>Company Tracking Number:</i>	<i>EWEB-67-10</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Application for Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Internet Term Life Insurance Application/EWEB-67-10</i>		

We have bracketed the additional detail questions under each main underwriting question in order to indicate that the additional detailed questions will only show on the copy of the application printed in an Insured's policy if those particular detailed questions were asked of the proposed insured. For example, if the proposed insured answered "No" to the Question 2 in the Medical Section indicating that he/she had never had any of the 8 medical conditions listed, then the detailed questions for those medical conditions would not be asked and the detailed questions would not show in the printed application. However, if the proposed insured answered "Yes" that he/she had High Blood Pressure, for example, the High Blood Pressure detailed questions would be asked and would show in the final printed application. I assure you that the only variability to the detailed questions is whether or not the detailed questions will show on the printed application. No questions will be added, deleted, or changed without refiling the application for approval.

Also, we have bracketed the following references in order to provide flexibility in updating these areas without refiling: the rider/benefit references on form TPROD-68-10; and the time ranges in certain medical questions.

If you have any questions or need further information, please contact me at the 617-578-4730 or kpoor@metlife.com.

Enclosures: Readability Certificate; Certification

## Company and Contact

### Filing Contact Information

Karen Poor, Senior Contract Consultant	KPoor@metlife.com
501 Boylston Street	617-578-4730 [Phone]
Boston, MA 02116	617-578-5505 [FAX]

### Filing Company Information

MetLife Investors USA Insurance Company	CoCode: 61050	State of Domicile: Delaware
222 Delaware Ave. Suite 900	Group Code: 241	Company Type: Life
P.O. Box 25130	Group Name: MetLife Group	State ID Number:
Wilmington, DE 19899	FEIN Number: 54-0696644	
(617) 578-2000 ext. [Phone]		

-----

## Filing Fees

SERFF Tracking Number: METD-126382418 State: Arkansas  
Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
Company Tracking Number: EWEB-67-10  
TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: Application for Life Insurance  
Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: DE charges \$50 per form; therefore we are submitting \$100.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MetLife Investors USA Insurance Company	\$100.00	02/12/2010	34159796

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/08/2010	04/08/2010
Approved-Closed	Linda Bird	02/17/2010	02/17/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Life Insurance	Diane Palermo	04/08/2010	04/08/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open filing	Note To Filer	Linda Bird	04/07/2010	04/07/2010

*SERFF Tracking Number:*      *METD-126382418*                      *State:*                      *Arkansas*  
*Filing Company:*              *MetLife Investors USA Insurance Company*      *State Tracking Number:*      *44831*  
*Company Tracking Number:*      *EWEB-67-10*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium*

*Product Name:*              *Application for Life Insurance*  
*Project Name/Number:*      *Internet Term Life Insurance Application/EWEB-67-10*

## **Disposition**

Disposition Date: 04/08/2010

Implementation Date:

Status: Approved-Closed

Comment: Company has made changes to the original submission.

Rate data does NOT apply to filing.

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Certification		Yes
Supporting Document	Webscreen		Yes
Form (revised)	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes
Form	Term Product Supplement		Yes

*SERFF Tracking Number:*      *METD-126382418*                      *State:*                      *Arkansas*  
*Filing Company:*              *MetLife Investors USA Insurance Company*      *State Tracking Number:*      *44831*  
*Company Tracking Number:*      *EWEB-67-10*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium*

*Product Name:*              *Application for Life Insurance*  
*Project Name/Number:*      *Internet Term Life Insurance Application/EWEB-67-10*

## **Disposition**

Disposition Date: 02/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Certification		Yes
Supporting Document	Webscreen		Yes
Form (revised)	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes
Form	Term Product Supplement		Yes

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

**Amendment Letter**

Submitted Date: 04/08/2010

**Comments:**

Thank you for re-opening this filing. We have made the following two changes to the Agreement section of the EWEB-67-10 application form: 1) we have removed reference to reading the application from the first sentence of the Agreement since when electronically signed in a tele-application process the applicant won't actually read the printed application prior to providing their electronic signature; and 2) we have removed the last bullet of the Agreement section concerning receiving the Company's Privacy Notice and the Life Insurance Buyer's Guide as we have decided that we do not need the applicant to agree in the application that they have received these documents. I assure you that application form EWEB-67-10 has not been implemented and the changes to the form do not affect any certifications we have made as part of this filing. Thank you for your assistance with this matter and I apologize for any inconvenience.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
EWEB-67-10	Application/Enrollment Form	Application for Life Insurance	Initial				65.100	EWEB-67-10 (Bracketed-AR,NM,OH,OK6).pdf

*SERFF Tracking Number:*      *METD-126382418*                      *State:*                      *Arkansas*  
*Filing Company:*              *MetLife Investors USA Insurance Company*      *State Tracking Number:*      *44831*  
*Company Tracking Number:*      *EWEB-67-10*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium*

*Product Name:*              *Application for Life Insurance*  
*Project Name/Number:*      *Internet Term Life Insurance Application/EWEB-67-10*

**Note To Filer**

**Created By:**

Linda Bird on 04/07/2010 08:37 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

04/07/2010 08:37 AM

**Subject:**

Request to re-open filing

**Comments:**

Filing has been re-opened as requested.

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	EWEB-67-10	Application/ Enrollment Form Application for Life Insurance	Initial		65.100	EWEB-67-10 (Bracketed-AR,NM,OH,O K6).pdf
	TPROD-68-10	Application/ Enrollment Form Term Product Supplement	Initial		73.800	TPROD-68-10 (FINAL).pdf

Application for Life Insurance

MetLife Investors USA Insurance Company (Referred to as "the Company".)

IS THIS APPLICATION BEING COMPLETED IN THE UNITED STATES?  Yes  No

SECTION I - About the Proposed Insured

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Country of Legal Residence \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-Mail \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Gender  Male  Female \_\_\_\_\_ Place of Birth (State/Country) \_\_\_\_\_ Social Security Number \_\_\_\_\_

U.S. Driver's License  Passport  State Issued ID  Employment Authorization Document (EAD) Card

Issuer of ID \_\_\_\_\_ ID Number \_\_\_\_\_ Expiration Date (if any) \_\_\_\_\_

Are you a U.S. Citizen?  Yes  No

If NO, Country of Citizenship? \_\_\_\_\_

How long have you lived in the U.S.? \_\_\_\_\_

Do you have Permanent Resident status in the U.S.?  Yes  No

NON U.S. PERMANENT RESIDENTS ONLY - Country of Permanent Residence \_\_\_\_\_

Do you have a U.S. Visa?  Yes  No

If YES, U.S. Visa Type \_\_\_\_\_ Visa Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

If NO Visa, do you have an Employment Authorization Document (EAD) Card?  Yes  No

If YES, what is the EAD Class? \_\_\_\_\_

If NO EAD Card, do you have a Visa/Immigration application pending with the USCIS?  Yes  No

If YES, Application Number: \_\_\_\_\_

SECTION II - Employment

EMPLOYMENT STATUS:  Currently Employed  Student  Homemaker  Unemployed

Currently Employed:

Name of Employer \_\_\_\_\_

Work Address: City \_\_\_\_\_ State/Country \_\_\_\_\_

Position/Duties \_\_\_\_\_

Are you currently working and performing your usual job duties?  Yes  No

If YES, Annual Income: \$ \_\_\_\_\_

If NO, why are you unable to work?  Physical/Mental Impairment  Family Medical Leave

Physical/Mental Impairment:

Why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes  No  Unknown/Unsure

If YES, annual income prior to disability: \$ \_\_\_\_\_



If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Main Source of Income:

- Long Term Disability       Worker's Compensation       Charitable Organization       Government Assistance
- Social Security Disability       Savings/Investments       Short Term Disability       Family Members
- Other, please enter details. \_\_\_\_\_

**Family Medical Leave:**

This leave is related to:  Birth/Adoption       Family       Other

If **BIRTH/ADOPTION** or **FAMILY**, Annual Income: \$ \_\_\_\_\_

If **OTHER**, please answer the following questions:

Why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes       No       Unknown/Unsure

If **YES**, annual income prior to disability: \$ \_\_\_\_\_

If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Current Annual Income: \$ \_\_\_\_\_

Main Source of Income:

- Long Term Disability       Worker's Compensation       Charitable Organization       Government Assistance
- Social Security Disability       Savings/Investments       Short Term Disability       Family Members
- Other, please enter details. \_\_\_\_\_

**Student:**

Annual Income: \$ \_\_\_\_\_

What is the main source of your remaining support?

- Parent       Grandparent       Grants       Spouse/Civil Union/Domestic Partner
- Sibling       Savings/Investments       Student Loans
- Other, please enter details. \_\_\_\_\_

**Homemaker:**

Annual Household Income: \$ \_\_\_\_\_

What is the main source of your household income?

- Parent       Grandparent       Government Assistance/Social Security       Disability Income
- Sibling       Savings/Investments       Unemployment Benefits       Spouse/Civil Union/Domestic Partner
- Other, please enter details. \_\_\_\_\_

If **YES** to Disability Income, are you receiving disability income due to your personal disability?  Yes       No

If **YES**, why are you unable to work? \_\_\_\_\_

**Unemployed:**

What is the main source of your income?

- Parent       Grandparent       Government Assistance/Social Security       Disability Income
- Sibling       Savings/Investments       Unemployment Benefits       Spouse/Civil Union/Domestic Partner
- Other, please enter details. \_\_\_\_\_

Annual Income: \$ \_\_\_\_\_

If **YES** to Disability Income, are you receiving disability income due to your personal disability?  Yes       No

If **YES**, why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes       No       Unknown/Unsure

If **YES**, annual income prior to disability: \$ \_\_\_\_\_

Have you been previously employed?  Yes       No



If **YES**, please answer the following questions.

What was your last date of employment? \_\_\_\_\_

What was the name of your employer? \_\_\_\_\_

What was your position/duties? \_\_\_\_\_

How long did you work there? \_\_\_\_\_

What was your annual income with your former employer? \_\_\_\_\_

If **NO**, are you a student?

Yes  No

Will you pay for this life insurance policy with your earned income (for example, annual salary)?

Yes  No

If **NO**, what is the source of the payments for this life insurance policy?

- Savings/Investments     Grandparent     Parent     Spouse/Civil Union/Domestic Partner
- Sibling     Loans     Use of Values from another Life Insurance/Annuity Contract
- Other - Please enter details: \_\_\_\_\_

### SECTION III - Beneficiary

Beneficiary Type:     Individual     Trust

Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured (You)	Percentage of Proceeds (if not equal)
Primary				
<input type="checkbox"/> Primary				
<input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary				
<input type="checkbox"/> Contingent				

Check here to include all living and future natural or adopted children as Contingent Beneficiaries. (Name all living children above.)

Trust Name \_\_\_\_\_

Social Security Number/TIN \_\_\_\_\_ Date Established \_\_\_\_\_ % of Proceeds \_\_\_\_\_

Beneficiary Type     Primary     Contingent

Trustee Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### SECTION IV - Existing or Applied-for Coverage

1. Do you have any existing or applied-for life insurance or annuities with this or any other company?     Yes     No

If **YES**, please provide details about your existing **Life** insurance and any **Life** insurance policies you have applied for.

Company	Amount of Insurance	Status
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For

2. By applying for this life insurance policy, do you plan to cancel, withdraw money from, take a loan from, reduce premium payments for, or otherwise change an existing life insurance policy or annuity?     Yes     No



3. Have you ever had an application for life, disability income or health insurance declined, postponed (temporarily declined), issued/offered with an increase in premium or modified due to risk factors?  Yes  No

If **YES**, please fill in the details below:

Type of Insurance: Life/Health/ Disability	Action Taken (Declined, Postponed, Increased Premium, Modified)	Reason for Action (Medical, occupation, foreign travel, residence, aviation, hazardous sports, driving, other, unknown/unsure)	Year Action Occurred

**SECTION V - Payment Information**

Who is paying for this policy?  Self  Other  
 If Other, please answer the following: Payor Name \_\_\_\_\_ Relationship to Proposed Insured (You) \_\_\_\_\_

Please enter Billing Address if different from your Residence Address.  
 Billing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAYMENT METHOD** (Check the appropriate ONE.)

[Electronic Funds Transfer]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly  Monthly   
 Existing Electronic Payment Number \_\_\_\_\_  
 If you are the bank account holder, please fill out the following bank account information. If the Other Payor is the bank account holder, the Other Payor must complete the Electronic Payment (EP) Account Agreement form.  
 Name of Financial Institution: \_\_\_\_\_  
 Bank Account Type:  Checking  Savings  
 Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_  
 Debit will take place this date: \_\_\_\_\_  
 Amount Collected with Application: \_\_\_\_\_ (Must be at least 1/12 of an annual premium.)

[Direct Bill/Check]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly   
 Amount Collected with Application: \_\_\_\_\_ (Must be at least 1/12 of an annual premium.)

[Debit/Credit Card]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly  Monthly   
 [Visa]  [MasterCard]  [American Express]  [Discover]  
 Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ [CCV #:] \_\_\_\_\_

**SECTION VI - General Questions**

1. In the past [three] years, have you flown in a plane other than as a passenger on a commercial airline or do you have plans to do so in the next 12 months?  Yes  No

2. In the past [three] years, have you participated in or do you plan to participate in **any** of the following? Check **ALL** that apply.

Underwater sports - SCUBA diving, skin diving, or similar activities  Outdoor rock or mountain climbing or similar activities  
 Racing sports - motorcycle, auto, motor boat or similar activities  Bungee jumping or similar activities  
 Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities  
 None of the Above

In the past 24 months have you participated in or do you plan in the next 12 months to participate in any of these activities outside of the United States/Canada?  Yes  No





3. Have you ever been convicted of or pled Guilty or No Contest to a felony?  Yes  No

If **YES**, please answer the following:

Are you currently incarcerated?  Yes  No

Are you currently on parole or probation?  Yes  No

Was a weapon used in the commission of the felony?  Yes  No

Date of Conviction: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What charges were you convicted of? \_\_\_\_\_

Was any penalty imposed?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

4. Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past [five] years?  Yes  No

If **YES** - Please check **ALL** that apply:

Suspended/Revoked  DUI or DWI  Moving Violations in the past [five] years

**Suspended/Revoked:**

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?  
\_\_\_\_\_

Was any penalty imposed?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any other related charges?  Yes  No

If **YES**, please provide details for related charges below.

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?  
\_\_\_\_\_

Was any penalty imposed?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any accident(s) involved?  Yes  No

If **YES**, please answer the following:

Were there damages to persons, property, or both?  Yes  No

If **YES**, please select:  Person(s)  Property  Both

Were there any fatalities involved?  Yes  No

Please provide results of any legal proceedings. \_\_\_\_\_



**DUI or DWI:**

How many times have you been convicted of DUI/DWI? \_\_\_\_\_

Date of DUI/DWI: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Driver's License Number Involved: \_\_\_\_\_

Were there any other related charges?  Yes  No

If **YES**, please provide details for related charges below.

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, leaving the scene of an accident, vehicular homicide, other)?  
\_\_\_\_\_

Was any penalty imposed?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any accident(s) involved?  Yes  No

If **YES**, please answer the following:

Were there damages to persons, property, or both?  Yes  No

If **YES**, please select:  Person(s)  Property  Both

Were there any fatalities involved?  Yes  No

Please provide results of any legal proceedings.  
\_\_\_\_\_

Has your license been suspended?  Yes  No

If **YES**, please provide current status:  Active  Inactive  Suspended  Revoked  Other

If **Other**, please provide details. \_\_\_\_\_

What were you under the influence of?  Drugs  Alcohol  Both

**Alcohol/Both**

A. Describe your current alcohol consumption:

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months how often did you have more than four drinks in one day? \_\_\_\_\_

B. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? \_\_\_\_\_

How many drinks did you have on a typical day when you were drinking? \_\_\_\_\_

In a typical 12 month period, how often did you have more than four drinks in one day? \_\_\_\_\_

C. Are you currently in a support group?  Yes  No



5. Have you **traveled** or **resided** outside of the U.S. or Canada in the past 24 months; or do you plan to **travel** or **reside** outside of the U.S or Canada in the next 12 months?

Yes  No

If **YES**, please provide details.

Past	Future	Duration (weeks)	Countries	Purpose
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

If **YES**, please provide the information below for planned future travel.

- A. Do you plan to participate in any missionary, journalistic, diplomatic, or medical work?  Yes  No
- B. What cities/regions of this country will you be visiting? \_\_\_\_\_
- C. What activities have you planned while visiting this country? \_\_\_\_\_
- D. Do you plan to visit non-urban areas?  Yes  No
- E. Will you consider visiting war zones or hazardous areas of this country?  Yes  No
- F. What is the availability of medical facilities, if needed? \_\_\_\_\_
- G. What type of transportation will you use for travel to and from the area? \_\_\_\_\_
- H. Will you be attending a conference/seminar sponsored by a corporation, foundation or industry group or something similar?  Yes  No
- I. Will you be staying at an all-inclusive resort?  Yes  No
- J. What is the name of the resort? \_\_\_\_\_
- K. What type of accommodations will you stay in? \_\_\_\_\_
- L. Will you be going on an expedition/safari?  Yes  No
- M. Will you be traveling with a group?  Yes  No
- N. What travel company is hosting the trip? \_\_\_\_\_
- O. How large is the group? \_\_\_\_\_
- P. Are there any special security arrangements to help ensure the group's safety?  Yes  No

6. In the past [five] years, have you used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)?

Yes  No

If **YES**, type of product used:

Product(s)	Date Last Used

If Cigars, number per year: \_\_\_\_\_



**SECTION VII - Health Questions**

1. Height (ft. in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

2. Have you ever been diagnosed, received treatment, or consulted with a health care professional for any of the following? Check **ALL** that apply.

- High Blood Pressure     High Cholesterol     Cancer     Diabetes     Rheumatoid Arthritis     Systemic Lupus
- Neurological Disorder (Mental Retardation, Multiple Sclerosis, Paralysis, Seizures, Other) (excluding headaches and migraine headaches)
- Emotional or Psychological Disorder (Anxiety, Depression, Eating Disorder, Other)
- None of the Above

**HIGH BLOOD PRESSURE:**

In the past [10] years, have you been hospitalized for high blood pressure?

Yes     No

If **NO**, please answer the following.

A. Are you taking any medications for high blood pressure?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

B. Have you had your blood pressure taken in the past [12] months?

Yes     No

If **YES**, do you remember your most recent blood pressure reading?

Yes     No

If **YES**, what was the reading? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**HIGH CHOLESTEROL:**

A. Have you had your cholesterol tested in the past [12] months?

Yes     No

If **YES**, please answer the following.

Do you know the results of your most recent cholesterol reading?

Yes     No

If **YES**, please enter the reading: \_\_\_\_\_

B. Are you taking any medications for cholesterol?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**CANCER:**

A. Are you currently receiving any treatment for the cancer?

Yes     No

B. What was the location and type of cancer?

Location \_\_\_\_\_ Type \_\_\_\_\_  Check if Unknown

C. When was the cancer diagnosed? Date \_\_\_\_\_



D. What was the stage of cancer you had:

- Stage 0     Stage 1     Stage 2     Stage 3     Stage 4     Unknown

E. Had the cancer spread to your lymph nodes or any other site?

Yes     No

F. What treatments did you receive for the cancer? Check **ALL** that apply.

- Chemotherapy     Radiation     Surgery
- Other, please explain \_\_\_\_\_

G. When was the treatment completed? Date \_\_\_\_\_

Yes     No

H. Has there ever been a recurrence of the cancer?

Yes     No

I. Has any other treatment, surgery, testing or other follow-up (other than your regular check-up) been discussed, suggested or planned for the cancer?

Yes     No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**DIABETES:**

A. Did you have diabetes only during pregnancy?

Yes     No

If **YES**, please complete the following.

Are you currently pregnant?

Yes     No

If **NO**, please complete the following.

Are you currently being treated for diabetes?

Yes     No

If **NO**, please complete the following.

Has your blood sugar returned to normal?

Yes     No

B. In the past [five] years, have you been hospitalized for diabetes?

Yes     No

C. Have you ever been diagnosed as having kidney disease or protein in your urine?

Yes     No

D. Have you ever been diagnosed as having Retinopathy or Diabetic related eye problems?

Yes     No

E. Have you ever been diagnosed as having Diabetic related neuropathy?

Yes     No

F. Have you had any other complications of diabetes (skin infections, poor circulation, other)?

Yes     No

If **YES**, please provide details. \_\_\_\_\_

G. How old were you when the diabetes was diagnosed? \_\_\_\_\_

H. Have you had a check-up with a health care professional for diabetes in the past [12] months?

Yes     No

I. Are you taking any medications for diabetes?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**RHEUMATOID ARTHRITIS:**

A. Have you been diagnosed as having heart, lung, or kidney problems related to rheumatoid arthritis?  Yes  No

B. Are you taking any medications for rheumatoid arthritis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

Have you had any changes to your medications in the past [12] months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

C. Have you had any joints replaced?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

D. Are you limited in any activities due to rheumatoid arthritis?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to rheumatoid arthritis? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**NEUROLOGICAL DISORDER:**

If **YES**, what was the diagnosis? Check **ALL** that apply.

Mental Retardation  Multiple Sclerosis  Paralysis  Seizures

Other - Please answer the questions in **Section X - Other**.

**Multiple Sclerosis:**

A. Were you diagnosed with multiple sclerosis in the past [12] months?  Yes  No

B. How old were you when the multiple sclerosis was diagnosed? \_\_\_\_\_

C. Have you been hospitalized in the past [three] years for multiple sclerosis?  Yes  No

D. Are you able to walk?  Yes  No

[If **YES**, do you require an aid (cane, walker, other)?]   Yes  No

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to multiple sclerosis? \_\_\_\_\_

F. Are you currently taking or have you taken in the past 12 months any medications for multiple sclerosis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

G. In the past [24] months have you had any symptoms of multiple sclerosis?  Yes  No

If **YES**, please describe your symptoms. \_\_\_\_\_ ]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**Paralysis:**

- A. Was this Bell's Palsy only?  Yes  No
- B. Was the onset of the paralysis in the past 12 months?  Yes  No
- C. Was the paralysis caused by trauma or an accident?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

D. What part of your body is affected by this condition (one arm, both arms, one leg, both legs, other)?  
\_\_\_\_\_ ]

E. Are you able to walk?  Yes  No

If **YES**, do you require an aid (cane, walker, other)?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

F. Do you use a urinary catheter?  Yes  No

G. Do you have any kidney impairment other than kidney stones?  Yes  No

H. Do you have any complications such as infections, skin ulcers or kidney stones?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

If **YES**, are you receiving any treatment for the complications?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Seizures:**

A. What type of seizures do you have? Check **ALL** that apply.

- Tonic-clonic/Grand mal
- Absence/Petit mal
- Focal/Partial
- Febrile
- Unknown

Other - Please provide details. \_\_\_\_\_

B. Is there a known cause for the seizures?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

C. How old were you when the seizures were diagnosed? \_\_\_\_\_

D. Was your last seizure in the past 12 months?  Yes  No

If **YES**, how many seizures did you have in the past 12 months? \_\_\_\_\_ ]

If **NO**, date of last seizure: \_\_\_\_\_ ]

E. Are you taking any medications for seizures?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

F. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

G. Have you had any surgery for seizures?  Yes  No

If **YES**, date of surgery? \_\_\_\_\_ ]

H. Are you prevented from holding a driver's license or are your activities restricted in any other way due to seizures?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**EMOTIONAL OR PSYCHOLOGICAL DISORDER:**

If **YES**, what was the diagnosis? Check **ALL** that apply.

Yes  No

Anxiety  Depression  Eating Disorder  Other - Please answer the questions in **Section X - Other**.

**Anxiety:**

A. Have you been hospitalized in the past [five] years for anxiety?  Yes  No

Yes  No

B. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anxiety? \_\_\_\_\_

C. Have you ever attempted to end your life?  Yes  No

Yes  No

D. Are you taking any medications for anxiety?  Yes  No

Yes  No

If **YES**, please list medications. \_\_\_\_\_

E. Have you had any changes to your medications in the past 12 months?  Yes  No

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Depression:**

A. Have you ever been diagnosed with bipolar disease or manic depression?  Yes  No

Yes  No

B. Have you been hospitalized in the past [five] years for depression?  Yes  No

Yes  No

C. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to depression? \_\_\_\_\_

D. Have you ever attempted to end your life?  Yes  No

Yes  No

E. Are you taking any medications for depression?  Yes  No

Yes  No

If **YES**, please list medications. \_\_\_\_\_

F. Have you had any changes to your medications in the past 12 months?  Yes  No

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**Eating Disorder:**

If **YES**, what type of eating disorder? Check **ALL** that apply.

- Anorexia Nervosa
- Bulimia
- Other - Please provide details. \_\_\_\_\_

A. Are you currently in remission?

Yes  No

If **YES**, how long have you been in remission? \_\_\_\_\_

B. How old were you when this eating disorder began? \_\_\_\_\_

C. Have you ever had any relapses (eating disorder went into remission but then recurred)?

Yes  No

If **YES**, how many relapses have you had? \_\_\_\_\_

D. How long have you been at your current weight? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

3. Other than as indicated above, have you ever had any disease or disorder of any of the following? Check **ALL** that apply.

- Heart (Congenital Heart Disease, Coronary Artery Disease, Heart Attack, Heart Murmur, Valvular Heart Disease, Other)
- Arteries / Veins (Aneurysm, Carotid Artery Disease, Stroke, Transient Ischemic Attacks (TIA), Other) (excluding varicose veins)
- Kidneys (Glomerulonephritis, Kidney Failure, Kidney Transplant, Nephritis, Nephrotic Syndrome, Polycystic Kidney Disease, Pylonephritis, Other) (excluding kidney stones)
- Lungs / Respiratory System (Asthma, Chronic Bronchitis, Cystic Fibrosis, Sleep Apnea, Other) (excluding colds)
- Liver (Cirrhosis, Hepatitis, Other)  Blood (Anemia, Leukemia, Other)
- Gastrointestinal/Digestive System (Crohn's Disease, Pancreatitis, Ulcerative Colitis, Other)
- None of the Above

**HEART:**

What was the diagnosis? Check **ALL** that apply.

- Congenital Heart Disease
- Heart Attack
- Valvular Heart Disease
- Coronary Artery Disease
- Heart Murmur
- Other - Please answer the questions in **Section X - Other**.

**Congenital Heart Disease:**

Which of the following have you ever had? Check **ALL** that apply.

- Atrial Septal Defect (ASD)
- Ebstein's Anomaly
- Tetralogy of Fallot
- Unknown
- Bicuspid Aortic Valve
- Hypoplastic Left Heart Syndrome
- Transposition of the Great Arteries
- Coarctation of the Aorta
- Patent Ductus Arteriosus (PDA)
- Tricuspid Atresia
- Dextrocardia
- Pulmonary Atresia
- Ventricular Septal Defect (VSD)
- Other - Please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



Atrial Septal Defect (ASD):

A. Was the ASD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

Bicuspid Aortic Valve:

A. Have you had any surgery or is surgery planned or recommended by a health care professional?

Yes  No

B. Do you have any symptoms related to heart disease?

Yes  No

C. Do you have any associated aortic stenosis or aortic insufficiency?

Yes  No

Unknown

D. Do you have any other heart or blood vessel abnormality?

Yes  No

E. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

G. Do you have any physical limitations due to heart disease?

Yes  No

Dextrocardia:

A. Do you have any other heart or other congenital abnormalities?

Yes  No

B. Do you have any physical limitations due to the dextrocardia?

Yes  No

C. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Patent Ductus Arteriosus (PDA):

A. Was the PDA surgically corrected before age five?

Yes  No

If **NO**, did the PDA close on its own before age five?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No



**Heart Murmur:**

Was it described as or diagnosed as: Check **ALL** that apply.

- Functional, Innocent, or a Flow Murmur
- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Atrial Septal Defect (ASD)
- Unknown
- Mitral Stenosis
- Mitral Valve Prolapse
- Mitral Insufficiency (Regurgitation)
- Pulmonary Insufficiency (Regurgitation)
- Other - Please provide details. \_\_\_\_\_
- Tricuspid Insufficiency (Regurgitation)
- Pulmonary Stenosis
- Tricuspid Stenosis
- Ventricular Septal Defect (VSD)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Functional, Innocent, or a Flow Murmur:

- A. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- B. Do you have any physical limitations due to heart disease?  Yes  No
- C. Have you been advised to have a follow-up echocardiogram?  Yes  No

Atrial Septal Defect (ASD):

- A. Was the ASD surgically corrected?  Yes  No
- If **YES**, was the surgery prior to age five?  Yes  No
- If **NO**, is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- C. Do you have any physical limitations due to heart disease?  Yes  No
- D. Do you have any other heart abnormality?  Yes  No

Mitral Insufficiency (Regurgitation):

- A. Do you have any shortness of breath or limited exercise tolerance related to mitral insufficiency (regurgitation)?  Yes  No
- B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No
- C. Has the mitral insufficiency (regurgitation) been described as:
  - Trivial/Slight    Mild    Moderate    Severe    Unknown
- D. Do you have any other heart abnormality including any other valvular disease?  Yes  No
- E. Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- G. Do you have any physical limitations due to heart disease?  Yes  No
- H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years?  Yes  No  Unknown

Mitral Valve Prolapse:

- A. Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?  Yes  No
- C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No



D. Do you have any mitral insufficiency (regurgitation)?

Yes  No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

F. Do you have any physical limitations due to heart disease?

Yes  No

G. Do you have any other heart abnormality including any other valvular disease?

Yes  No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

**Valvular Heart Disease:**

Have you had valve surgery?

Yes  No

Which of the following valve diseases do you have? Check **ALL** that apply.

- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Mitral Stenosis
- Unknown
- Mitral Insufficiency (Regurgitation)
- Mitral Valve Prolapse
- Pulmonary Stenosis
- Other - Please provide details. \_\_\_\_\_
- Pulmonary Insufficiency (Regurgitation)
- Tricuspid Stenosis
- Tricuspid Insufficiency (Regurgitation)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Mitral Insufficiency (Regurgitation):

A. Do you have any shortness of breath or limited exercise tolerance related to the mitral insufficiency (regurgitation)?

Yes  No

B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

C. Has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

D. Do you have any other heart abnormality including any other valvular disease?

Yes  No

E. Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

G. Do you have any physical limitations due to heart disease?

Yes  No

H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years?

Yes  No  
 Unknown

Mitral Valve Prolapse:

A. Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?

Yes  No

C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No



D. Do you have any mitral insufficiency (regurgitation)?

Yes  No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

F. Do you have any physical limitations due to heart disease?

Yes  No

G. Do you have any other heart abnormality including any other valvular disease?

Yes  No

**ARTERIES/VEINS:**

What was the diagnosis? Check **ALL** that apply.

Aneurysm  Carotid Artery Disease  Stroke  Transient Ischemic Attacks (TIAs)  
 Other - Please answer the questions in **Section X - Other**.

**LUNG/RESPIRATORY SYSTEM:**

What was the diagnosis? Check **ALL** that apply.

Asthma  Chronic Bronchitis  Cystic Fibrosis  Sleep Apnea  
 Other - Please answer the questions in **Section X - Other**.

**Asthma:**

A. Have you been hospitalized overnight for asthma in the past [24] months?

Yes  No

B. Have you visited the emergency room or an urgent care center in the past [24] months related to asthma?

Yes  No

If **YES**, how many times have you been to the emergency room or an urgent care center related to asthma in the past [24] months? \_\_\_\_\_

When was the last time you were in an emergency room or an urgent care center related to asthma? \_\_\_\_\_

C. Have you had asthma symptoms in the past [six] months (other than with exercise)?

Yes  No

If **YES**, how often do your symptoms occur? \_\_\_\_\_ per week

D. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to asthma? \_\_\_\_\_

E. Other than inhalers, are you currently taking any medications for asthma?

Yes  No

If **YES**, please list medications. \_\_\_\_\_

F. Have you taken oral steroid pills in the past [12] months for asthma?

Yes  No

If **YES**, how many episodes/attacks of asthma required taking oral steroid pills in the past [12] months? \_\_\_\_\_

Were any courses of steroids longer than a continuous two week period? \_\_\_\_\_

Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Chronic Bronchitis:**

A. Have you been hospitalized for chronic bronchitis in the past [three] years?

Yes  No

B. Do you have three or more attacks of bronchitis per year?

Yes  No

C. Do you have complete recovery (no symptoms) between episodes of bronchitis?

Yes  No

D. Do you have any ongoing underlying lung disease other than asthma?

Yes  No

If **YES**, please provide details. \_\_\_\_\_



E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to bronchitis? \_\_\_\_\_

F. Are you taking any medications for chronic bronchitis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

G. Have you required oral steroid pills in the past [12] months for bronchitis?  Yes  No

Unknown

If **YES**, how many episodes of bronchitis have required taking oral steroid pills in the past [12] months? \_\_\_\_\_

Were any courses of steroids longer than a continuous two week period?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Sleep Apnea:**

A. What is your current treatment?

- CPAP/BIPAP  Dental Appliance  Surgery  Weight Loss  No Treatment

If **YES** to CPAP/BIPAP, have you used this for more than six months on a nightly basis?  Yes  No

If **YES** to Weight Loss or No Treatment, please select any other treatments that were recommended by your health care professional:

- CPAP/BIPAP  Dental Appliance  Surgery  None

Yes  No

B. Do you have any ongoing symptoms due to sleep apnea?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**KIDNEYS:**

Are you on dialysis?  Yes  No

If **NO**, what was the diagnosis? Check **ALL** that apply.

- Glomerulonephritis  Kidney Transplant  Nephrotic Syndrome  Pyelonephritis  
 Kidney Failure  Nephritis  Polycystic Kidney Disease  
 Other - Please answer the questions in **Section X - Other**.

**Pyelonephritis:**

Which of the following applies to your history of pyelonephritis:  Chronic  Acute  Unknown

Have you had more than one episode of acute pyelonephritis?  Yes  No

Do you have abnormal kidney function or continuous urine abnormalities?  Yes  No

Are you taking any medications for pyelonephritis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**LIVER:**

What was the diagnosis? Check **ALL** that apply.

Cirrhosis     Hepatitis A     Hepatitis B     Hepatitis C     Hepatitis - Type Unknown

[If Type A, has it been more than three months since you recovered from your Hepatitis A?]  Yes  No

Other - Please answer the questions in **Section X - Other**.

**GASTROINTESTINAL / DIGESTIVE SYSTEM:**

What was the diagnosis? Check **ALL** that apply.

Crohn's Disease     Pancreatitis     Ulcerative Colitis

Other - Please answer the questions in **Section X - Other**.

**Crohn's Disease:**

A. How old were you when the Crohn's Disease was diagnosed? \_\_\_\_\_

B. Has any surgery been recommended or has surgery been planned for the next 12 months?  Yes  No

C. Have you ever had any surgery for Crohn's Disease?  Yes  No

How many surgeries? \_\_\_\_\_

If **YES**, when was the last surgery? \_\_\_\_\_

D. Other than for surgery, have you been hospitalized for Crohn's Disease in the past [three] years?  Yes  No

E. Do you have any complications from Crohn's Disease (strictures, obstruction, abscess, fistulas, liver disease, anemia, other)?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

F. Have you had any weight loss due to Crohn's Disease in the past 12 months?  Yes  No

G. Please describe any symptoms of Crohn's Disease you have had in the past 12 months (fever, abdominal pain, diarrhea, other)? How often?

Symptom(s) \_\_\_\_\_ Frequency \_\_\_\_\_

H. Are you taking any medications for Crohn's Disease?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

I. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

J. Have you taken oral or intravenous steroids in the past 12 months?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**Pancreatitis:**

- A. What type of pancreatitis:  Acute  Chronic
- B. Cause of acute pancreatitis:  Gallstones  Alcohol  Unknown or Other
- If Gallstones:
  - Did you have your gallbladder removed?  Yes  No
  - If **YES**, have you had any symptoms since your gallbladder was removed?  Yes  No
  - If **NO**, how many episodes of acute pancreatitis have you had? \_\_\_\_\_
  - When was the last episode? \_\_\_\_\_

**Ulcerative Colitis**

- A. How old were you when the ulcerative colitis was diagnosed? \_\_\_\_\_
- B. Has any surgery been recommended or has surgery been planned for the next 12 months?  Yes  No
- C. Have you ever had any surgery for ulcerative colitis?  Yes  No
  - If **YES**, when was the surgery? Date \_\_\_\_\_
  - Did you have your entire colon removed (total colectomy)?  Yes  No
- D. Other than for surgery, have you been hospitalized for ulcerative colitis in the past [three] years?  Yes  No
- E. Do you know which part of your colon is diseased?  Yes  No
  - Which part:  Rectum only (ulcerative proctitis)
  - Sigmoid and rectum
  - More extensive than just Sigmoid and Rectum
- F. Do you have any complications from ulcerative colitis (cholangitis, liver disease, anemia, other)?  Yes  No
  - If **YES**, please provide details. \_\_\_\_\_
- G. Have you had any weight loss due to ulcerative colitis in the past 12 months?  Yes  No
- H. Please describe any ulcerative colitis symptoms you have had in the past 12 months (fever, abdominal pain, diarrhea, blood in stool, other)? How often?
 

Symptoms \_\_\_\_\_ Frequency \_\_\_\_\_
- I. Are you taking any medications for ulcerative colitis?  Yes  No
  - If **YES**, please list medications. \_\_\_\_\_
- J. Have you had any changes to your medications in the past 12 months?  Yes  No
  - If **YES**, please provide details. \_\_\_\_\_
- K. Have you taken oral steroid pills or intravenous steroids in the past 12 months for ulcerative colitis?  Yes  No
- L. When was your last colonoscopy? Date \_\_\_\_\_
- M. What were the findings? (Please include any evidence of dysplasia/pre-malignancy.)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**BLOOD:**

What was the diagnosis? Check **ALL** that apply.

- Anemia
- Leukemia
- Other - Please answer the questions in **Section X - Other**.

**Anemia:**

What type of anemia? Check **ALL** that apply.

- Iron Deficiency Anemia
- Sickle Cell Anemia
- Unknown
- Anemia Due to Blood Loss
- Thalassemia
- Other - Please provide details.

A. What is the source of blood loss? \_\_\_\_\_

B. Was heavy menses the source of blood loss?  Yes  No

If **NO**, please provide details. \_\_\_\_\_

C. How old were you when the anemia was diagnosed? \_\_\_\_\_

D. Have you ever been hospitalized due to anemia?  Yes  No

If **YES**, when were you hospitalized? \_\_\_\_\_

If **YES**, why were you hospitalized? \_\_\_\_\_

E. What treatment (including transfusions) have you received for anemia?  
\_\_\_\_\_

F. Are you currently receiving treatment for anemia?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

G. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anemia? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

4. Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group?  Yes  No

If **YES**, please indicate which substance you were using:  Alcohol  Drugs  Both

**Alcohol/Both:**

A. Was this recommendation or counseling related to a DUI/DWI?  Yes  No

If **YES**, please answer the following questions.

1. Describe your current alcohol consumption:

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months, how often did you have more than four drinks in one day? \_\_\_\_\_

2. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? \_\_\_\_\_

How many drinks did you have on a typical day when you were drinking? \_\_\_\_\_

In a typical 12 month period, how often did you have more than four drinks in one day? \_\_\_\_\_



3. Are you currently in a support group?

Yes  No

If **NO**, when did you last drink alcohol? \_\_\_\_\_

Have you ever had a relapse (stopped using and then restarted using alcohol)?

Yes  No

Are you currently in a support group?

Yes  No

B. Have you ever had any medical complications due to drinking (liver disease, pancreatitis, other)?

Yes  No

Please provide the name and address (or any other contact information) of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

5. Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?

Yes  No

A. Please indicate the name of the drug or drugs used. Check **ALL** that apply.

Cocaine  Marijuana  Hallucinogens  Barbiturates

Heroin  Narcotics  Amphetamines

Other Illicit Drugs/Controlled Substances

Please provide details. \_\_\_\_\_

**MARIJUANA ONLY:**

Have you used Marijuana in the past 12 months?

Yes  No

If **YES**, how often do you use Marijuana per month? \_\_\_\_\_

Yes  No

B. Have you ever injected these drugs?

Yes  No

C. How old were you when you started using drugs? \_\_\_\_\_

D. When did you last use drugs? Date: \_\_\_\_\_

E. Have you ever sought counseling or medical attention because of your use of drugs (including hospitalization, in-patient and out-patient, rehabilitation)?

Yes  No

If **YES**, what was the date of your last treatment? Date: \_\_\_\_\_

F. Have you ever had a relapse (stopped using and then restarted using drugs)?

Yes  No

G. Do you drink alcohol?

Yes  No

If **YES**, answer the following questions describing your current alcohol consumption.

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months, how often did you have more than four drinks in one day? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

6. Have you ever been diagnosed with or treated by a health care professional for Acquired Immune Deficiency Syndrome (AIDS)?

Yes  No



7. Have you ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus?  Yes  No
8. In the past [three] years, have you consulted a health care professional for a routine checkup or physical exam?  Yes  No
9. Other than previously disclosed, are you using any prescription medications?  Yes  No

If **YES**, please provide the names of all medications and the reason for each.

Names	Reason

10. Other than as indicated previously, in the past five years, have you been overnight in a hospital or other medical facility (excluding for childbirth, kidney stones, gallstones)?  Yes  No

If **YES**, please explain the reason for your stay and when this occurred.

Reason \_\_\_\_\_ When \_\_\_\_\_

11. Do you plan on scheduling surgery or any other medical procedure in the next [six] months that would require an overnight hospital stay (excluding for childbirth)?  Yes  No

If **YES**, what surgery or medical procedure and when is this scheduled?

Procedure \_\_\_\_\_ When \_\_\_\_\_

### SECTION VIII - Family History

Which of the following conditions has any parent or sibling been diagnosed with **prior to age [60]**? Check **ALL** that apply.

- Prostate Cancer     Ovarian Cancer     Lung Cancer     Congestive Heart Failure     Stroke  
 Breast Cancer     Colon Cancer     Melanoma     Aneurysms     Diabetes  
 Heart Attack/Coronary Artery Disease (Myocardial Infarction, Angina, Other)  
 None of the Above

Which of the following conditions has any parent or sibling been diagnosed with **at any age**? Check **ALL** that apply.

- Familial Colon Polyposis     Huntington's Chorea     Polycystic Kidney Disease  
 None of the Above

Please complete the following information for each family member diagnosed with any of the above conditions.

Relationship to Proposed Insured (You)	Age if Living	Age at Death	Specific Condition(s) (list all that apply)

If Familial Colon Polyposis:

- Have you had a colonoscopy in the past three years?  Yes  No  
 Were the results reported as normal?  Yes  No

### SECTION IX - Military

- A. Are you a member of the military services?  Yes  No
- B. Are you a dependent of a member of the military services?  Yes  No
- C. Do you serve in any of these special forces: Navy SEALs; Air Force Special Forces; Army Rangers; Delta Force; Army Special Forces?  Yes  No
- D. What is your current paygrade?  E1 thru E4     Higher than E4
- E. Are you being deployed abroad in the next 12 months?  Yes  No  
 Unknown

If **YES**, please provide details (when, where, what capacity)? \_\_\_\_\_



**SECTION X - Other**

A. What is the disease or disorder? \_\_\_\_\_

B. How old were you when you were diagnosed with the disease or disorder? \_\_\_\_\_

C. Do you currently have this disease or disorder?  Yes  No

If **NO**, when was the last time that you had symptoms related to this disease or disorder? \_\_\_\_\_

D. Have you had any surgery for this disease or disorder?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

What Surgery \_\_\_\_\_ When was the Surgery \_\_\_\_\_

E. Other than surgery, have you been hospitalized for this disease or disorder?  Yes  No

If **YES**: Why \_\_\_\_\_ When were you hospitalized \_\_\_\_\_

F. In the past [12] months what treatments have you received related to this disease or disorder?  
\_\_\_\_\_

G. What treatments are you currently receiving related to this disease or disorder?  
\_\_\_\_\_

H. Are you taking any medications for this disease or disorder?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

I. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

J. Has a health care professional recommended any future surgery or procedures related to this disease or disorder?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

K. Except for scheduled health care appointments, have you missed any time from work or school in the past [12] months related to this disease or disorder?  Yes  No

How much time \_\_\_\_\_ Why \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Additional Information**

---

---

---

---

---

---

---

---

---

---



## Agreement / Disclosure

To the best of my knowledge and belief, all statements in this application for life insurance, including any amendments and supplements, are true and complete. I also agree that:

- My statements in this application and any amendments and supplements are the basis of any policy issued.
- This application and any amendments and supplements will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application including any amendments and supplements.
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No insurance will take effect until a policy is delivered to me and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) my condition of health is the same as stated in the application; and (b) I have not received any medical advice or treatment from a health care professional since the date of the application. If either (a) or (b) is not true, please contact the Company for re-evaluation of your application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I have requested a payment method of Electronic Funds Transfer from my bank account, I authorize the Company to initiate debit entries through Metropolitan Life Insurance Company to the deposit account identified in the application, using the Automatic Clearing House. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and my Financial Institution time to act on it.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**

## Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

## Signatures

Signature of Proposed Insured

Date

Signed at City, State

\_\_\_\_\_





**Term Product Supplement**

---

**MetLife Investors USA Insurance Company**

**This Supplement will be attached to and become part of the Application with which it is used.**

Product Name

---

Face Amount

---

**Benefits and Riders:**

- Disability Waiver
- Convertible Disability Waiver
- Accelerated Death Benefit
- Long Term Care Guaranteed Purchase Option (LTC GPO)
- Other \_\_\_\_\_ \$ \_\_\_\_\_



SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> AR READABILITY CERTIFICATION.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> Not applicable for this filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Life & Annuity - Acturial Memo		
<b>Bypass Reason:</b> Not applicable for this filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Certification		
<b>Comments:</b>		
<b>Attachment:</b> AR CERTIFICATION.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Webscreen		
<b>Comments:</b>		
<b>Attachment:</b>		

*SERFF Tracking Number:*      *METD-126382418*                      *State:*                      *Arkansas*  
*Filing Company:*              *MetLife Investors USA Insurance Company*      *State Tracking Number:*      *44831*  
*Company Tracking Number:*      *EWEB-67-10*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.103 Renewable - Single Life -  
Fixed/Indeterminate Premium*

*Product Name:*              *Application for Life Insurance*  
*Project Name/Number:*      *Internet Term Life Insurance Application/EWEB-67-10*

**Final Application Wireframes - 020810.pdf**

## State of Arkansas

### Readability Certification

Pursuant to Bulletin 14-79 and Arkansas Statute Annotated § 23-80-206 to § 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act, the Flesch Readability Ease Test has been applied to the following forms.

<b>Form Number(s)</b>	<b>Flesch Score(s)</b>
EWEB-67-10	65.1
TPROD-68-10	73.8



---

Karen Johnson, Vice President

12/28/2009

---

Date

MetLife Investors USA Insurance Company  
P.O. Box 25130, Wilmington, DE 19899

## State of Arkansas

### Certification

We certify compliance with Rule and Reg. 19 s 10 and all other applicable requirements of the Arkansas Insurance Department.



---

Karen Johnson, Vice President

12/28/2009

---

Date

About You



### About You

- About You
- Payment
- Beneficiaries
- Agreement
- Completion**

Go to:

- Profile
- Health
- Diabetes
- Felony
- Health pt 2
- Family History
- General
- Existing Insurance

For the purpose of this application, "you" refers to the Proposed Insured.

Is this application being completed in  Yes  No the United States?

### Basic Information

First Name

Middle Name (optional)

Last Name

Suffix (optional)

Email

Gender  Male  Female

Date of Birth

Place of Birth

State

Are you a US citizen?  Yes  No

If US citizen = "No", Non-US Citizen Conditional Questions are shown – see following pages

Activates following "State" field if "United States"

### Residence

Street Address (no p.o. boxes)

City

State

Zip Code

Country of Legal Residence

continued from previous page ...

Primary Phone

Green labels populate from EOT data

Alternate Phone (optional)

### Identification

Social Security Number

US Driver's License

I do not have a US Driver's License .....

See Driver's License conditional pages for additional scenarios

Issuer of ID

Expiration Date

### Employment

Employment Status

Options:  
- Currently Employed  
- Unemployed  
- Homemaker  
- Student

See following pages for conditional questions that appear based on the Employment Status selected.

Save & Exit

Continue



## Non-US Citizen Conditional Questions - 1/2

The following conditional questions are shown if the user indicates they are not a US-Citizen.

Are you a US citizen?  Yes  No

Country of Citizenship

How long have you lived in the US?  years  months

Do you have Permanent Resident status in the United States?  Yes  No

Country of Permanent Residence

Do you have a US Visa?  Yes  No

If less than a year, results in Need to Go Offline Overlay – Too Little Time Living in US

Shown if “Permanent Resident Status” = “No”

### User Indicates they have a US Visa

Are you a US citizen?  Yes  No

Country of Citizenship

How long have you lived in the US?  years  months

Do you have Permanent Resident status in the United States?  Yes  No

Do you have a US Visa?  Yes  No

US Visa Type

Visa Number

Expiration Date

### User Indicates they don't have a US Visa, but do have an EAD Card

Are you a US citizen?  Yes  No

Country of Citizenship

How long have you lived in the US?  years  months

Do you have Permanent Resident status in the United States?  Yes  No

Do you have a US Visa?  Yes  No

Do you have an Employment Authorization Document (EAD) Card?  Yes  No

EAD Class

The user is asked their EAD Class if they indicate they have an EAD card

Values:  
- A5  
- C8  
- C9  
- Other

## Non-US Citizen Conditional Questions - 2/2

### User Indicates they don't have a US Visa or EAD Card

Are you a US citizen?

Yes  No

Country of Citizenship

- Select Country -

How long have you lived in the US?

years  months

Do you have Permanent Resident status in the United States?

Yes  No

Do you have a US Visa?

Yes  No

Do you have an Employment Authorization Document (EAD) Card?

Yes  No

Do you have a Visa/Immigration application pending with the USCIS?

Yes  No

Application Number

If they have a pending application they are asked for the application number

# Drivers Lic Conditional

User indicates they do not have a US Driver's License but has a Passport

## Identification

Social Security Number

C1

US Driver's License Number

C2

I do not have a US Driver's License

Please select a form of identification

- Passport  
 State-Issued ID  
 Employment Authorization Document (EAD) Card

ID Number

Issuer of ID

- Select Country -

C3

Expiration Date

- Month -

- Day -

- Year -

C4

User indicates they do not have a US Driver's License but has a US State-Issued ID

## Identification

Social Security Number

C1

US Driver's License Number

C2

I do not have a US Driver's License

Please select a form of identification

- Passport  
 US State-Issued ID  
 Employment Authorization Document (EAD) Card

ID Number

Issuer of ID

- Select State -

C3

Expiration Date

- Month -

- Day -

- Year -

C4

User indicates they do not have a US Driver's License but has an EAD Card

## Identification

Social Security Number

C1

US Driver's License Number

C2

I do not have a US Driver's License

Please select a form of identification

- Passport  
 US State-Issued ID  
 Employment Authorization Document (EAD) Card

ID Number

Expiration Date

- Month -

- Day -

- Year -

C4

## Employment & Existing Life Insurance

# Employment - Conditional Questions - 1/4

## User Indicates They are "Currently Employed" and "Performing Usual Job Duties"

Employment Status

Name of Employer

Work address is a foreign address

Work Address

Position / Duties

Are you currently working and performing your usual job duties?  Yes  No

Annual Income

Will you pay for this life insurance policy with your earned income? (for example: annual salary)  Yes  No

What is the source of the payments for this life insurance policy?

Please enter details

If 'Work address is a foreign address' is checked, then a Country field is shown instead.

This field provides auto-complete from a database of job positions

Shown only when answer to salary paying insurance is 'No'

- Options:
- Spouse / Civil Union / Domestic Partner
  - Sibling
  - Parent
  - Grandparent
  - Loans
  - Savings / Investments
  - Use of values from another life insurance / annuity contract
  - Other

Shown when "main source of payments" is "Other"

# Employment - Conditional Questions - 2/4

## User Indicates They are "Currently Employed" and NOT "Performing Usual Job Duties"

Employment Status

Name of Employer

Work address is a foreign address

Work Address

If 'Work address is a foreign address' is checked, then a Country field is shown instead.

Position / Duties

Are you currently working and performing your usual job duties?  Yes  No

Why are you unable to work?  Mental or physical impairment  Family medical leave

Shown if user is not performing their usual job duties

This leave is related to:  Birth/Adoption  Family  Other

Shown if unable to work due to "Family medical leave"

Annual income

Shown if unable to work due to "Birth/Adoption" or "Family"

Why are you unable to work?

Shown if "Mental or physical impairment" or "Family medical leave": "Other"

Shown if unable to work due to "Family medical leave" or Mental/Physical Impairment

Do you expect to return to work within 6 months?  Yes  No  Unknown/Unsure

Shown if 'expect to return to work?' is "No" or "Unknown/Unsure"

Main Source of Income

- Options:
- Family members
  - Long Term disability
  - Social Security Disability
  - Worker's Compensation
  - Savings / Investments
  - Government assistance
  - Short Term disability
  - Charitable organization
  - Other

Please enter details

Annual income prior to disability

Shown if Main Source of Income is "Other"

Current annual income

Shown if 'expect to return to work?' is "Yes"

Will you pay for this life insurance policy with your earned income? (for example: annual salary)  Yes  No

Shown if "Family Medical Leave" & "Expect to return to work?" is "No" or "Unknown/unsure"

If "no", see follow-up question on Employment 1/4 page

## Employment - Conditional Questions - 3/4

### User Indicates They are a "Student"

Employment Status

Annual Income

What is the main source of your remaining support?

Please enter details

Will you pay for this life insurance policy with your earned income? (for example: annual salary)  Yes  No

If "no", see follow-up question on Employment 1/4 page

Appears when income < \$5K

Options:  
- Spouse/Civil Union/Domestic Partner  
- Parent  
- Sibling  
- Grandparent  
- Savings/Investments  
- Grants  
- Student Loans  
- Other

Shown when "main source of payments" is "Other"

### User Indicates They are a "Homemaker"

Employment Status

Annual Household Income

What is the main source of your household income?

Are you receiving disability income due to your personal disability?  Yes  No

Why are you unable to work?

Please enter details

Will you pay for this life insurance policy with your earned income? (for example: annual salary)  Yes  No

If "no", see follow-up question on Employment 1/4 page

Appears when income >= \$15K

Options:  
- Spouse/Civil Union/Domestic Partner  
- Parent  
- Sibling  
- Grandparent  
- Disability income  
- Savings/Investments  
- Government Assistance/Social Security  
- Unemployment Benefits  
- Other

Appears when source of support is "Disability income"

Appears when "Disability income due to personal disability" is "Yes"

Shown when "main source of household income" is "Other"

## Employment - Conditional Questions - 4/4

### User Indicates They are "Unemployed"

Employment Status

What is the main source of your income?

- Options:
- Spouse/Civil Union/Domestic Partner
  - Parent
  - Sibling
  - Grandparent
  - Disability income
  - Savings/Investments
  - Government Assistance/Social Security
  - Unemployment Benefits
  - Other

Please enter details

Shown when "main source of income" is "Other"

Annual Income

Are you receiving disability income due to your personal disability?  Yes  No

Why are you unable to work?

These questions appear if "personal disability" is "yes"

Do you expect to return to work within 6 months?  Yes  No  Unknown/Unsure

Annual income prior to disability

Appears if "expect to return to work within 6 months" is "yes"

Have you been previously employed?  Yes  No

What was your last date of employment?

What was the name of your employer?

What was your position/duties?

How long did you work there?  years  months

These questions appear if user was previously employed.

What was your annual income with your former employer?

Occupation auto-complete

Are you a student?  Yes  No

Appears if user was \*not\* previously employed

Will you pay for this life insurance policy with your earned income? (for example: annual salary)  Yes  No

If "no", see follow-up question on Employment 1/4 page

### Existing Insurance & Annuities

About You | Payment | Beneficiaries | Agreement | **Completion**

Go to:

Do you have any existing or applied-for life insurance or annuities with this or any other company?  Yes  No

*(Exclude group insurance through an employer or association)*

If answer to existing insurance question = "Yes", then replacement question will appear.

Type of Product  Life Insurance  Annuities  Both

Appears if "Yes". If "Life Insurance" or "Both" is selected, then gather details on existing life insurance further down

By applying for this life insurance policy, do you plan to cancel, withdraw money from, take a loan from, reduce premium payments for, or otherwise change an existing life insurance policy or annuity?  Yes  No

If answer to existing insurance question = "Yes", then replacement question will appear.

Please provide details about your existing life insurance and any life insurance policies you have applied for. Click "Add Another Policy" after each entry. If you don't have this information, you may return to your application after you get it.

Section to gather details on existing life ins. Policies. Data fields would repeat if user chooses to "Add Another", each section would have a "Delete" link above when added.

	<a href="#">Delete</a>
Company	<input type="text"/>
Amount of Insurance	<input type="text"/>
Status	<input type="radio"/> Existing <input type="radio"/> Applied-For

Auto-complete list of insurers

Button (or link) disabled until required information has been entered.

If "Yes", then reflexive questions for this section appear.

Have you ever had an application for life, disability income or health insurance declined, postponed (temporarily declined), issued/offered with an increase in premium or modified due to risk factors?  Yes  No



Past Application

Have you ever had an application for life, disability income or health insurance declined, postponed (temporarily declined), issued/offered with an increase in premium or modified due to risk factors?

Yes  No

Please provide details for each application

APP

Type of Insurance  Life  Disability  Health

Action Taken   2

Reason for Action   3

Please specify  Shows if reason = "other"

Year action occurred

Add another application

- 2 Declined
- Postponed
- Modified
- Increased Premium

- 3 Medical
- Occupation
- Driving
- Foreign Travel
- Residence
- Aviation
- Hazardous Sports
- Unknown/Unsure
- Other

## Health Section and Additional Reflexive Questions



# About You

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

In This Step

## Health

It's important that you answer honestly.

1 Height 6 ft. 1 in. 1 Weight 185 lbs.

### Tobacco, Alcohol and Controlled Substances

- In the past 5 years, have you used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)?  Yes  No
- Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group?  Yes  No
- Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?  Yes  No

TREAT  
DRUG

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

Find Answers

Chat Live with a Representative

Contact Metlife

### Medical Conditions

Con-  
ditions

- Have you ever been diagnosed, received treatment, or consulted with a health care professional for any of the following? (check all that apply)
  - Cancer
  - Diabetes
  - Emotional or psychological disorder (Anxiety, Depression, Eating Disorder, Other)
  - High blood pressure
  - High cholesterol
  - Systemic Lupus
  - Neurological disorder (Mental Retardation, Multiple Sclerosis, Paralysis, Seizures, Other) (excluding headaches and migraine headaches)
  - Rheumatoid arthritis
  - None of the above
- Other than as indicated above, have you ever had any disease or disorder of the following? (check all that apply)
  - Arteries/Veins (Aneurysm, Carotid Artery Disease, Stroke, Transient Ischemic Attacks (TIA), Other) (excluding varicose veins)
  - Blood (Anemia, Leukemia, Other)
  - Gastrointestinal/Digestive System (Crohn's Disease, Pancreatitis, Ulcerative Colitis, Other)
  - Heart (Congenital Heart Disease, Coronary Artery Disease, Heart Attack, Heart Murmur, Valvular Heart Disease, Other)
  - Kidney (Glomerulonephritis, Kidney Failure, Kidney Transplant, Nephritis, Nephrotic Syndrome, Polycystic Kidney Disease, Pylonephritis, Other) (excluding kidney stones)
  - Liver (Cirrhosis, Hepatitis, Other)
  - Lungs/Respiratory System (Asthma, Chronic Bronchitis, Cystic Fibrosis, Sleep Apnea, Other) (excluding colds)
  - None of the above
- Have you ever been diagnosed with or treated by a health care professional for Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
- Have you ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus?  Yes  No

### Medical Attention and Prescriptions

- In the past three years, have you consulted a health care professional for a routine checkup or physical exam?  Yes  No
- Other than previously disclosed, are you using any prescription medications?  Yes  No
- Other than as indicated previously, in the past 5 years, have you been overnight in a hospital or other medical facility (excluding for childbirth, kidney stones, gallstones)?  Yes  No
- Do you plan on scheduling surgery or any other medical procedure in the next 6 months that would require an overnight hospital stay? (excluding for childbirth)  Yes  No

[Edit Previous](#) | [Save and Complete Later](#)

Continue

No.	Notes
1	Values carried over from Quick Quote



# About You

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

**In This Step**

## Health

It's important that you answer honestly.

**1** Height  ft.  in. **1** Weight  lbs.

### Tobacco, Alcohol and Controlled Substances

1. In the past 5 years, have you used tobacco or nicotine products in any form (e.g.,  Yes  No cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)?

Select types of products used (check all that apply)

Cigarettes  
 Date last used  /  **1**

Cigars  
 Date last used  /  **2**  
 Number per year

- Cigarillos
- Pipes
- Chewing tobacco
- Nicotine gum
- Nicotine patches

2. Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group?  Yes  No

3. Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?  Yes  No **3**

TREAT

DRUG

### Medical Conditions

4. Have you ever been diagnosed, received treatment, or consulted with a health care professional for any of the following? (check all that apply)

- Cancer
- Diabetes **4**
- Emotional or psychological disorder (Anxiety, Depression, Eating Disorder, Other)
- High blood pressure
- High cholesterol
- Systemic Lupus
- Neurological disorder (Mental Retardation, Multiple Sclerosis, Paralysis, Seizures, Other) (excluding headaches and migraine headaches)
- Rheumatoid arthritis
- None of the above

5. Other than as indicated above, have you ever had any disease or disorder of the following? (check all that apply)

- Arteries/Veins (Aneurysm, Carotid Artery Disease, Stroke, Transient Ischemic Attacks (TIA), Other) (excluding varicose veins)
- Blood (Anemia, Leukemia, Other)
- Gastrointestinal/Digestive System (Crohn's Disease, Pancreatitis, Ulcerative Colitis, Other)
- Heart (Congenital Heart Disease, Coronary Artery Disease, Heart Attack, Heart Murmur, Valvular Heart Disease, Other)
- Kidney (Glomerulonephritis, Kidney Failure, Kidney Transplant, Nephritis, Nephrotic Syndrome, Polycystic Kidney Disease, Pylonephritis, Other) (excluding kidney stones)
- Liver (Cirrhosis, Hepatitis, Other)
- Lungs/Respiratory System (Asthma, Chronic Bronchitis, Cystic Fibrosis, Sleep Apnea, Other) (excluding colds)
- None of the above

6. Have you ever been diagnosed with or treated by a health care professional for Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No

7. Have you ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus?  Yes  No

Continued on next page

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

- Find Answers
- Chat Live with a Representative
- Contact Metlife

No.	Notes
<b>1</b>	Shown for all except cigars
<b>2</b>	Shown for cigars
<b>3</b>	If user answered that they used drugs or "both" in prior question on counseling, this would be pre-selected as "Yes". If they try to change it, it will be flagged for underwriter review.

Where indicated by: **Medication details**

*Prior to medication being added*

Are you taking any medications....  Yes  No

Name of Medication

*After medication(s) is added*

Are you taking any medications....  Yes  No

Name of Medication  
[Delete](#)

[Delete](#)

Where indicated by: **PROVIDE DOCTOR INFORMATION**

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Name of Health Care Professional / Facility Name

**1**  Check if this is a foreign address

Street Address

City  State  Zip

Phone Number

**1** If "foreign" is checked, "state" dropdown becomes "country"

\* See next page for "Health Professional Clipboard" functionality

TREAT

Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group?

Yes  No

Please indicate which substance you were using:

Alcohol  Drugs  Both

Please be sure to provide details regarding the drug(s) below in Question 3.

Shows if substance = "Drugs" or "Both"

Was this recommendation or counseling related to a DUI/DWI?  Yes  No

Describe your **current** alcohol consumption

How often do you drink alcohol?  
(e.g., "10 times per week", "15 times per month")

times per

How many drinks do you have on a typical day when you are drinking?

In the past 3 months how often did you have more than 4 drinks in one day?

Shows if related to DUI/DWI = "Yes"

Describe your **past** alcohol consumption around the time of your DUI/DWI

How often did you drink alcohol?

(e.g., "10 times per week", "15 times per month")

times per

How many drinks did you have on a typical day when you were drinking?

In a typical 12 month period, how often did you have more than 4 drinks in one day?

Are you currently in a support group?  Yes  No *Asked if DUI = Yes or No*

When did you last drink alcohol?  mm /  yyyy

Shows if related to DUI/DWI = "No"

Have you ever had a relapse (stopped using and then restarted using alcohol)?  Yes  No

Have you ever had any medical complications due to drinking (liver disease, pancreatitis, other)?  Yes  No

PROVIDE DOCTOR INFORMATION

Shows if "use" = "Yes"

Shows if substance = "Alcohol" or "Both"

2

(Hover to define "drink" 12 oz bottle/can beer, 1 oz hard alcohol, glass of wine)

Drugs

Note: Section outlined in pink may show up in DUI question if answered "No" here, but applicant said they had a drug-related DUI

DRUG

Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?

Yes  No

Please indicate the name of the drug or drugs used (check all that apply)

- Amphetamines
- Barbiturates
- Cocaine
- Hallucinogens
- Heroin
- Marijuana

Have you used Marijuana in the past 12 months?  Yes  No

How often do you use Marijuana per month?  times per month

Shows if only "marijuana" is selected

Narcotics

Other Illicit Drugs/Controlled Substances

Please provide the details.

Shows if "other" is selected

How old were you when you started using drugs?

When did you last use drugs?

 mm /  yyyy

Shows if any drug except for "Marijuana"

(Amphetamines / Barbiturates / Cocaine / Hallucinogens / Heroin / Narcotics)

Have you ever injected these drugs?

Yes  No

Have you ever sought counseling or medical attention because of your use of drugs (including hospitalization, in-patient and out-patient, rehabilitation)?

Yes  No

What was the date of your last treatment?

 mm /  yyyy

Shows if sought counseling = "Yes"

Have you ever had a relapse (stopped using and then restarted using drugs)?

Yes  No

Do you drink alcohol?

Yes  No

Describe your **current** alcohol consumption

How often do you drink alcohol?

2

(e.g., "10 times per week", "15 times per month")

 times per 

How many drinks do you have on a typical day when you are drinking?

In the past 3 months how often did you have more than 4 drinks in one day?  times

Shows if drink alcohol = "Yes"

Shows if "use" = "Yes"

PROVIDE DOCTOR INFORMATION

Conditions

### High blood pressure

In the past 10 years have you been hospitalized for high blood pressure?  Yes  No  
 Are you taking any medications for high blood pressure?  Yes  No

**Medication details** Shows if "medications = "yes"

Have you had your blood pressure taken in the past 12 months?  Yes  No  
 Do you remember your most recent blood pressure reading?  Yes  No Shows if "taken = "yes"

Systolic (top number)  Shows if remember most recent = "Yes"  
 Diastolic (bottom number)

**PROVIDE DOCTOR INFORMATION**

Shows if "hospitalized = "no"

### High cholesterol

Are you taking any medications for cholesterol?  Yes  No

**Medication details** Shows if "medications = "yes"

Have you had your cholesterol tested in the past 12 months?  Yes  No Shows if "tested = "yes"

Do you know the results of your most recent cholesterol reading?  Yes  No  
 Please enter the reading  Shows if know results = "Yes"

**PROVIDE DOCTOR INFORMATION**

Hover over for description:  
 "Total cholesterol is your serum number and not HDL, LDL or your ratio"

OTHER

### Arteries / Veins

What was the diagnosis? (check all that apply)

- Aneurysm
- Carotid Artery Disease
- Stroke
- Transient Ischemic Attacks (TIAs)
- Other

What is the disease or disorder?  Shows if "other"

*If user enters "pneumonia", display all "other" reflexive questions and refer to csr*

### Kidney

Are you on dialysis?  Yes  No

What was the diagnosis? (check all that apply)

- Glomerulonephritis
- Kidney failure
- Kidney transplant
- Nephritis
- Nephrotic syndrome
- Polycystic kidney disease
- Pyelonephritis

Which of the following applies to your history of pyelonephritis?  
 Chronic  Acute  Unknown

Have you had more than 1 episode of acute pyelonephritis?  Yes  No  
 Do you have abnormal kidney function or continuous urine abnormalities?  Yes  No  
 Are you taking any medications for pyelonephritis?  Yes  No

**PROVIDE DOCTOR INFORMATION**

Other  
 What is the disease or disorder?  Shows if "other"

*If user enters "Kidney infection" or "hydronephrosis", answer all questions and refer to csr*

Shows if dialysis = "no"

Shows if "Acute" or "Unknown" is selected

All Pyelonephritis get these

OTHER

Lungs / Respiratory System

DIAG

What was the diagnosis? (check all that apply)

Asthma

Have you been hospitalized overnight for asthma in the past 24 months?  Yes  No

Have you visited the emergency room or an urgent care center in the past 24 months related to asthma?  Yes  No

How many times have you been to the emergency room or an urgent care center related to asthma in the past 24 months?

When was the last time you were in an emergency room or an urgent care center related to asthma?  mm /  yyyy

Shows if visited emergency room = "Yes"

Have you had asthma symptoms in the past 6 months (other than with exercise)?  Yes  No

How often do your symptoms occur?  times per week *Shows if prior answer = "Yes"*

Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to asthma?

Other than inhalers, are you currently taking any medications for asthma?  Yes  No

**Medication details** *Shows if "medications" = "yes"*

Have you taken oral steroid pills in the past 12 months for asthma?  Yes  No

How many episodes/attacks of asthma required taking oral steroid pills in the past 12 months?

Were any courses of steroids longer than a continuous 2 week period?  Yes  No *Shows if prior answer = "Yes"*

**PROVIDE DOCTOR INFORMATION**

Shows if "Asthma" is selected

Shows if "Chronic Bronchitis" is selected

Chronic Bronchitis

Have you been hospitalized for chronic bronchitis in the past 3 years?  Yes  No

Do you have 3 or more attacks of bronchitis per year?  Yes  No

Do you have complete recovery (no symptoms) between episodes of bronchitis?  Yes  No

Do you have any ongoing underlying lung disease other than asthma?  Yes  No

Please provide details  *Shows if underlying = "Yes"*

Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to bronchitis?

Are you taking any medication for chronic bronchitis?  Yes  No

**Medication details** *Shows if "medications" = "yes"*

Have you required oral steroid pills in the past 12 months for bronchitis?  Yes  No  Unknown

How many episodes of bronchitis have required taking oral steroid pills in the past 12 months?  *Shows if prior answer = "Yes"*

Were any courses of steroids longer than a continuous 2 week period?  Yes  No *Shows if how many episodes = "1"*

**PROVIDE DOCTOR INFORMATION**

Cystic Fibrosis

Sleep Apnea

What is your current treatment? Please select  **1**

Have you used this for more than 6 months on a nightly basis?  Yes  No *Shows if treatment = "CPAP/BIPAP"*

Please select any other treatments that were recommended by your health care professional  CPAP/BIPAP  Dental appliance  Surgery  None *Shows if treatment = "Weight loss" or "no treatment"*

Do you have any ongoing symptoms due to sleep apnea?  Yes  No

**PROVIDE DOCTOR INFORMATION**

- 1** CPAP/BIPAP
- Dental appliance
- Surgery
- Weight loss
- No treatment

Shows if "Sleep Apnea" is selected

OTHER

Other

What is the disease or disorder?  *Shows if "other"*

*If user enter "pneumonia", display all "other" reflexive questions and refer to CSR*

Gastrointestinal

What was the diagnosis? (check all that apply)

Crohn's Disease

How old were you when the Crohn's Disease was diagnosed?

Has any surgery been recommended or has surgery been planned for the next 12 months?  Yes  No

Have you ever had any surgery for Crohn's Disease?  Yes  No

How many surgeries?

When was the last surgery?  mm /  yyyy

Shows if had surgeries = "Yes"

Other than for surgery, have you been hospitalized for Crohn's Disease in the past 3 years?  Yes  No

Do you have any complications from Crohn's Disease (strictures, obstruction, abscess, fistulas, liver disease, anemia, other)?  Yes  No

Please provide details

Shows if complications = "Yes"

Have you had any weight loss due to Crohn's Disease in the past 12 months?  Yes  No

Please describe any symptoms of Crohn's Disease you have had in the past 12 months (fever, abdominal pain, diarrhea, other)? How often?

Symptom  Frequency

2

Are you taking any medications for Crohn's Disease?  Yes  No

Medication details

Shows if "medications" = "yes"

Have you had any changes to your medications in the past 12 months?  Yes  No

Please provide details

Shows if changes = "Yes"

Shows if medications = "Yes"

Have you taken oral or intravenous steroids in the past 12 months?  Yes  No

PROVIDE DOCTOR INFORMATION

1  Gallstones  
 Alcohol  
 Other / Unknown

Pancreatitis

What type of pancreatitis?  Acute  Chronic Shows if "Pancreatitis" is selected

Cause of acute pancreatitis  Please select 1

Did you have your gallbladder removed?  Yes  No

Have you had any symptoms since your gallbladder was removed?  Yes  No Shows if gallbladder removed = "Yes"

How many episodes of acute pancreatitis have you had?

When was the last episode?  mm /  yyyy

Shows if gallbladder removed = "No"

Ulcerative colitis (Reflexive questions for this on next page)

Other

What is the disease or disorder?  Shows if "other"

Shows if "Crohn's" is selected

Shows if "Pancreatitis - acute" is selected

Shows if "cause" = gallstones

2 If multiple symptoms:

Symptom	Frequency
<input type="button" value="Delete"/> Fever	Twice per year
<input type="text"/>	<input type="text"/>
<input type="button" value="Add another symptom"/>	

Gastrointestinal

What was the diagnosis? (check all that apply)

- Crohn's
- Pancreatitis
- Ulcerative colitis

How old were you when the ulcerative colitis was diagnosed?

Has any surgery been recommended or has surgery been planned for the next 12 months?  Yes  No

Have you ever had any surgery for ulcerative colitis?  Yes  No

When was the surgery?  /

Did you have your entire colon removed (total colectomy)?  Yes  No

Other than for surgery, have you been hospitalized for ulcerative colitis in the past 3 years?  Yes  No

Do you know which part of your colon is diseased?  Yes  No

Which part?  **3**

Shows if surgery = "Yes"

**3**

- Rectum only (ulcerative proctitis)
- Sigmoid and rectum
- More extensive than just sigmoid and rectum

Do you have any complications from ulcerative colitis (cholangitis, liver disease, anemia, other)?  Yes  No

Please provide details

Shows if complications = "Yes"

Have you had any weight loss due to ulcerative colitis in the past 12 months?  Yes  No

Please describe any ulcerative colitis symptoms you have had in the past 12 months (fever, abdominal pain, diarrhea, blood in stool, other)? How often?

Symptom  Frequency

**4**

Shows if symptoms = "Yes"

Are you taking any medications for ulcerative colitis?  Yes  No

**Medication details**

Shows if "medications" = "yes"

Have you had any changes to your medications in the past 12 months?  Yes  No

Please provide details

Shows if changes = "Yes"

Shows if medications = "Yes"

Have you taken oral steroid pills or intravenous steroids in the past 12 months for ulcerative colitis?  Yes  No

When was your last colonoscopy?  /

What were the findings? (Please include any evidence of dysplasia/pre-malignancy.)

**PROVIDE DOCTOR INFORMATION**

Other

**OTHER**

What is the disease or disorder?  **Shows if "other"**

Shows if "Ulcerative colitis" is selected

**4** If multiple symptoms:

Symptom	Frequency
<a href="#">Delete</a> <input type="text" value="Fever"/>	<input type="text" value="Twice per year"/>
<input type="text"/>	<input type="text"/>
<input type="button" value="Add another symptom"/>	

**Liver**

What was the diagnosis? (check all that apply)

Cirrhosis

Hepatitis A

Has it been more than 3 months since you recovered from your Hepatitis A?  Yes  No *Shows if "Hepatitis A" is selected*

Hepatitis B

Hepatitis C

Hepatitis - Type unknown

Other *Shows if "Other" is selected*

**OTHER** What is the disease or disorder?  *Shows if "other"*

**Blood**

What was the diagnosis? (check all that apply)

Anemia

What type of anemia? (check all that apply)

Anemia due to blood loss  Thalassemia

Iron deficiency anemia  Sickle Cell Anemia

Other  Unknown

Please provide details  *Shows if "other"*

Was heavy menses the source of blood loss?  Yes  No **1** *Shows if user is female and source is due to blood loss or iron deficiency*

Please provide details  *Shows if heavy menses = "no"*

What is the source of blood loss?  *Shows if user is male*

How old were you when the anemia was diagnosed?

Have you ever been hospitalized due to anemia?  Yes  No

When were you hospitalized?  /

Why were you hospitalized?  *Shows if hospitalized = "Yes"*

What treatment (including transfusions) have you received for anemia?

Are you currently receiving treatment for anemia?  Yes  No

Please provide details  *Shows if treatment = "Yes"*

Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to anemia?

**PROVIDE DOCTOR INFORMATION**

Leukemia

Other

What is the disease or disorder?  *Shows if "other"*

**1 Logic point for females:**  
 Was heavy menses the source of blood loss?  
 If "Yes", then no further questions are displayed.

Medical Conditions - Cancer

Cancer

Are you currently receiving any treatment for the cancer?  Yes  No

What was the location and type of cancer?  Check if unknown

Location

Type

When was the cancer diagnosed? mm / yyyy

What was the stage of cancer you had? **1**

Had the cancer spread to your lymph nodes or any other site?  Yes  No

What treatment(s) did you receive for the cancer? (check all that apply)

- Chemotherapy
- Radiation
- Surgery
- Other

Please explain  Shows if "other" is selected

When was the treatment completed? mm / yyyy

Has there ever been a recurrence of the cancer?  Yes  No

Has any other treatment, surgery, testing, or other follow-up (other than your regular check-up) been discussed, suggested or planned for cancer?  Yes  No

Please provide details  Shows if other treatment, etc. = "Yes"

- 1**
- Stage 0
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unknown

PROVIDE DOCTOR INFORMATION

Medical Conditions - Diabetes

Rheumatoid arthritis

Diabetes

Shows if user is female

Did you have diabetes only during pregnancy?

Yes  No

Are you currently pregnant?

Yes  No

Shows if during pregnancy = "Yes"

Are you currently being treated for diabetes?

Yes  No

Shows if currently pregnancy = "No"

Has your blood sugar returned to normal?

Yes  No

Shows if currently being treated = "No"

In the past 5 years have you been hospitalized for diabetes?

Yes  No

Have you ever been diagnosed as having kidney disease or protein in your urine?

Yes  No

Have you ever been diagnosed as having Retinopathy or Diabetic related eye problems?

Yes  No

Have you ever been diagnosed as having Diabetic related neuropathy?

Yes  No

Have you had any other complications of diabetes (skin infections, poor circulation, other)?

Yes  No

Please provide details

Shows if other complications = "Yes"

How old were you when the diabetes was diagnosed?

Have you had a check-up with a health care professional for diabetes in the past 12 months?

Yes  No

Are you taking any medications for diabetes?

Yes  No

Medication details

Shows if "medications" = "yes"

PROVIDE DOCTOR INFORMATION

Rheumatoid arthritis

Have you been diagnosed as having heart, lung, or kidney problems related to rheumatoid arthritis?

Yes  No

Are you taking any medications for rheumatoid arthritis?

Yes  No

Medication details

Shows if "medications" = "yes"

Shows if medications = "Yes"

Have you had any changes to your medications in the past 12 months?

Yes  No

Please provide details

Shows if changes = "Yes"

Have you had any joints replaced?

Yes  No

Please provide details

Shows if joints = "Yes"

Are you limited in any activities due to rheumatoid arthritis?

Yes  No

Please provide details

Shows if limited = "Yes"

Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to rheumatoid arthritis?

PROVIDE DOCTOR INFORMATION

Heart

What was the diagnosis? (check all that apply)

- Congenital heart disease
- Coronary artery disease
- Heart attack
- Heart murmur
- Valvular heart disease

Have you had valve surgery?  Yes  No

Which of the following valve diseases do you have? (check all that apply)

- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Mitral Stenosis
- Mitral Insufficiency (Regurgitation)

Shows if "Mitral Regurgitation" is selected

Do you have any shortness of breath or limited exercise tolerance related to the mitral insufficiency (regurgitation)?  Yes  No

Has a health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No

Has the mitral insufficiency (regurgitation) been described as:

Do you have any other heart abnormality including any other valvular disease?  Yes  No

Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No

Do you have any physical limitations due to heart disease?  Yes  No

According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past 3 years?  Yes  No  Unknown

Mitral Valve Prolapse

Shows if "Mitral Valve Prolapse" is selected

Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No

Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?  Yes  No

Has your health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No

Do you have any mitral insufficiency (regurgitation)?  Yes  No

Has the mitral insufficiency (regurgitation) been described as:

Shows if insufficiency = "Yes"

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No

Do you have any physical limitations due to heart disease?  Yes  No

Do you have any other heart abnormality including any other valvular disease?  Yes  No

- Pulmonary Stenosis
- Pulmonary Insufficiency (Regurgitation)
- Tricuspid Stenosis
- Tricuspid Insufficiency (Regurgitation)
- Unknown
- Other

Please provide details

Shows if "other" is selected = "Yes"

PROVIDE DOCTOR INFORMATION

OTHER  Other

What is the disease or disorder?

Shows if "other"

1

Trivial / slight  
Mild  
Moderate  
Severe  
Unknown

Heart

1

Trivial / slight  
Mild  
Moderate  
Severe  
Unknown

What was the diagnosis? (check all that apply)

Congenital heart disease

Which of the following have you ever had? (check all that apply)

- Atrial Septal Defect (ASD)
- Patent Ductus Arteriosus (PDA)
- Bicuspid Aortic Valve
- Pulmonary Atresia
- Coarctation of the aorta
- Tetralogy of Fallot
- Dextrocardia
- Transposition of the Great Arteries
- Ebstein's Anomaly
- Tricuspid Atresia
- Hypoplastic Left Heart Syndrome
- Ventricular Septal Defect (VSD)
- Other
- Unknown

Please provide details

Shows if "other" is selected = "Yes"

Atrial Septal Defect (ASD)

- Was the ASD surgically corrected?  Yes  No
- Was the surgery prior to age 5?  Yes  No
- Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- Do you have any physical limitations due to heart disease?  Yes  No
- Do you have any other heart abnormality?  Yes  No

Shows if "surgically corrected" = "Yes"

Shows if "surgically corrected" = "No"

Bicuspid Aortic Valve

- Have you had any surgery or is surgery planned or recommended by a health care professional?  Yes  No
- Do you have any symptoms related to heart disease?  Yes  No
- Do you have any associated aortic stenosis or aortic insufficiency?  Yes  No
- Do you have any other heart or blood vessel abnormality?  Yes  No
- Has a health care professional at any time told you that you have an irregular/ abnormal heart rate?  Yes  No
- Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- Do you have any physical limitations due to heart disease?  Yes  No

Unknown

Dextrocardia

- Do you have any other heart or other congenital abnormalities?  Yes  No
- Do you have any physical limitations due to the dextrocardia?  Yes  No
- Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No

Patent Ductus Arteriosus (PDA)

- Was the PDA surgically corrected before age 5?  Yes  No
- Did the PDA close on its own before age 5?  Yes  No
- Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- Do you have any physical limitations due to heart disease?  Yes  No
- Do you have any other heart abnormality?  Yes  No

Shows if "surgically corrected" = "No"

Ventricular Septal Defect (VSD)

- Was the VSD surgically corrected?  Yes  No
- Was the surgery prior to age 5?  Yes  No
- Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- Do you have any physical limitations due to heart disease?  Yes  No
- Do you have any other heart abnormality?  Yes  No

Shows if "surgically corrected" = "Yes"

Shows if "surgically corrected" = "No"

PROVIDE DOCTOR INFORMATION

- Coronary artery disease
- Heart attack
- Heart murmur
- Valvular heart disease
- Other

OTHER

What is the disease or disorder?  Shows if "other"

Heart

What was the diagnosis? (check all that apply)

- Congenital heart disease
- Coronary artery disease
- Heart attack
- Heart murmur

Was it described as or diagnosed as (check all that apply):

- Functional, Innocent, or a Flow Murmur

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Do you have any physical limitations due to heart disease?

Yes  No

Have you been advised to have a follow-up echocardiogram?

Yes  No

Shows if "Functional, Innocent, or a Flow Murmur" is selected

- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Atrial Septal Defect (ASD)

Was the ASD surgically corrected?

Yes  No

Was the surgery prior to age 5?

Yes  No

Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Do you have any physical limitations due to heart disease?

Yes  No

Do you have any other heart abnormality?

Yes  No

- Mitral Stenosis

- Mitral Insufficiency (Regurgitation)

Do you have any shortness of breath or limited exercise tolerance related to the mitral insufficiency (regurgitation)?

Yes  No

Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

Has the mitral insufficiency (regurgitation) been described as:

Do you have any other heart abnormality including any other valvular disease?

Yes  No

Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Do you have any physical limitations due to heart disease?

Yes  No

According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past 3 years?

Yes  No  Unknown

- Mitral Valve Prolapse

Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?

Yes  No

Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

Do you have any mitral insufficiency (regurgitation)?

Yes  No

Has the mitral insufficiency (regurgitation) been described as:

Shows if insufficiency = "Yes"

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Do you have any physical limitations due to heart disease?

Yes  No

Do you have any other heart abnormality including any other valvular disease?

Yes  No

- Pulmonary Insufficiency (Regurgitation)
- Pulmonary Stenosis
- Tricuspid Insufficiency (Regurgitation)
- Tricuspid Stenosis

CONTINUED ON NEXT PAGE

Shows if "ASD" is selected

Shows if "Mitral Regurgitation" is selected

Shows if "Mitral Valve Prolapse" is selected

1

Trivial / slight  
Mild  
Moderate  
Severe  
Unknown

CONTINUED FROM PRIOR PAGE

Ventricular Septal Defect (VSD)

Shows if "VSD" is selected

Was the VSD surgically corrected?

Yes  No

Was the surgery prior to age 5?

Yes  No

Shows if "surgically corrected" = "Yes"

Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

Shows if "surgically corrected" = "No"

Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Do you have any physical limitations due to heart disease?

Yes  No

Do you have any other heart abnormality?

Yes  No

Unknown

Other

Please provide details

Shows if "other" is selected

PROVIDE DOCTOR INFORMATION

Valvular heart disease

Other

OTHER

What is the disease or disorder?

Shows if "other"

Medical Conditions – Neurological > Multiple Sclerosis  
 Neurological > Paralysis

Neurological

What was the diagnosis? (check all that apply)

- Mental Retardation
- Multiple Sclerosis

Shows if "Multiple Sclerosis" is selected

Were you diagnosed with multiple sclerosis in the past 12 months?  Yes  No

How old were you when the multiple sclerosis was diagnosed?

Have you been hospitalized in the past 3 years for multiple sclerosis?  Yes  No

Are you able to walk?  Yes  No

Do you require an aid (cane, walker, other)?  Yes  No

Shows if walk = "yes"

Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to multiple sclerosis?

Are you currently taking or have you taken in the past 12 months any medications for multiple sclerosis?  Yes  No

Medication details Shows if "medications" = "yes"

In the past 24 months have you had any symptoms of multiple sclerosis?  Yes  No

Please describe your symptoms

Shows if symptoms = "Yes"

PROVIDE DOCTOR INFORMATION

- Paralysis

Shows if "Paralysis" is selected

Was this Bell's Palsy only?  Yes  No If "yes", don't ask any more questions

Was the onset of the paralysis in the past 12 months?  Yes  No

Was the paralysis caused by trauma or an accident?  Yes  No

Please provide details  
 Shows if trauma = "Yes"

What part of your body is affected by this condition (one arm, both arms, one leg, both legs, other)?

Are you able to walk?  Yes  No

Do you require an aid (cane, walker, other)?  Yes  No Shows if walk = "yes"

Please provide details  
 Shows if aid = "Yes"

Do you use a urinary catheter?  Yes  No

Do you have any kidney impairment other than kidney stones?  Yes  No

Do you have any complications such as infections, skin ulcers or kidney stones?  Yes  No

Please provide details  
 Shows if complications = "yes"

Are you receiving any treatment for the complications?  Yes  No

Please provide details  
 Shows if treatments = "yes"

PROVIDE DOCTOR INFORMATION

- Seizures
- Other



What is the disease or disorder?  Shows if "other"

Neurological

What was the diagnosis? (check all that apply)

- Mental retardation
- Multiple Sclerosis
- Paralysis
- Seizures

What type of seizures do you have? (check all that apply)

- Tonic-clonic/Grand mal
- Febrile
- Absence/Petit mal
- Focal/Partial
- Other
- Unknown

Please provide details

Shows if type = "other"

Is there a known cause for the seizures?  Yes  No

Please provide details

Shows if know cause = "yes"

How old were you when the seizures were diagnosed?

Was your last seizure in the past 12 months?  Yes  No

How many seizures did you have in the past 12 months?

Shows if within last 12 months = "yes"

Date of last seizure

 / 

Shows if within last 12 months = "no"

Are you taking any medications for seizures?  Yes  No

Medication details

Shows if "medications" = "yes"

Have you had any changes to your medications in the past 12 months?  Yes  No

Please provide details

Shows if changes = "Yes"

Have you had any surgery for seizures?  Yes  No

Date of surgery  /

Shows if surgery = "Yes"

Are you prevented from holding a driver's license or are your activities restricted in any other way due to seizures?  Yes  No

Please provide details

Shows if prevented = "Yes"

PROVIDE DOCTOR INFORMATION

Other

What is the disease or disorder?

Shows if "other"

Shows if "Seizures" is selected

Shows if medications = "Yes"

OTHER

Emotional or Psychological

What was the diagnosis? (check all that apply)

Anxiety

- Have you been hospitalized in the past 5 years for anxiety?  Yes  No
- Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to anxiety?
- Have you ever attempted to end your life?  Yes  No
- Are you taking any medications for anxiety?  Yes  No

Shows if "Anxiety" is selected

Medication details

Shows if "medications" = "yes"

Have you had any changes to your medications in the past 12 months?  Yes  No

Shows if medications = "Yes"

Please provide details

Shows if changes = "Yes"

PROVIDE DOCTOR INFORMATION

Depression

- Have you ever been diagnosed with bipolar disease or manic depression?  Yes  No
- Have you been hospitalized in the past 5 years for depression?  Yes  No
- Except for scheduled health care appointments, how many work or school days have you missed in the past 12 months due to depression?
- Have you ever attempted to end your life?  Yes  No
- Are you taking any medications for depression?  Yes  No

Shows if "Depression" is selected

Medication details

Shows if "medications" = "yes"

Have you had any changes to your medications in the past 12 months?  Yes  No

Shows if medications = "Yes"

Please provide details

Shows if changes = "Yes"

PROVIDE DOCTOR INFORMATION

Eating Disorder

What type of eating disorder? (check all that apply)

Anorexia nervosa

- Are you currently in remission?  Yes  No
- How long have you been in remission?  Shows if remission = "yes"
- How old were you when this eating disorder began?
- Have you ever had any relapses (eating disorder went into remission but then recurred)?  Yes  No
- How many relapses have you had?  Shows if relapses = "yes"

Bulimia

- Are you currently in remission?  Yes  No
- How long have you been in remission?  Shows if remission = "yes"
- How old were you when this eating disorder began?
- Have you ever had any relapses (eating disorder went into remission but then recurred)?  Yes  No
- How many relapses have you had?  Shows if relapses = "yes"

Other

- Please provide details
- Are you currently in remission?  Yes  No
- How long have you been in remission?  Shows if remission = "yes"
- How old were you when this eating disorder began?
- Have you ever had any relapses (eating disorder went into remission but then recurred)?  Yes  No
- How many relapses have you had?  Shows if relapses = "yes"
- How long have you been at your current weight?  years  months

Shows if "Eating Disorders" is selected

Shows if "Other" is selected

PROVIDE DOCTOR INFORMATION

OTHER

Other

What is the disease or disorder?  Shows if "other"



This appears when a medical condition a user has is not listed and chooses "Other".  
Can occur multiple times throughout application.

Carries over from conditions screen where this is first answered

What is the disease or disorder?

How old were you when you were diagnosed with the disease or disorder?

Do you currently have this disease or disorder?  Yes  No

When was the last time that you had symptoms related to this disease or disorder?

Have you had any surgery for this disease or disorder?  Yes  No

What surgery?

When was the surgery?  
Month  / Year

Other than surgery have you been hospitalized for this disease or disorder?  Yes  No

Why?

When were you hospitalized?  
Month  / Year

In the past 12 months what treatments have you received related to this disease or disorder?

What treatments are you currently receiving related to this disease or disorder?

Has a health care professional recommended any future surgery or procedures related to this disease or disorder?  Yes  No

Please provide details

Except for scheduled health care appointments, have you missed any time from work or school in the past 12 months related to this disease or disorder?  Yes  No

How much time?

Why?

Are you taking any medications for this disease or disorder?  Yes  No

Name of Medication

Have you had any changes to your medications in the past 12 months?  Yes  No

Please provide details

**PROVIDE DOCTOR INFORMATION**

*Shows if currently have = "No"*

*Shows if surgery have = "Yes"*

*Shows if surgery have = "Yes"*

*Shows if surgery = "Yes"*

*Shows if missed time = "Yes"*

*Shows if medications = "Yes"*

*Shows if changes to medications = "Yes"*



# About You

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

Continued

**In This Step**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

[Find Answers](#)

[Chat Live with a Representative](#)

[Contact Metlife](#)

## Medical Attention and Prescriptions

8. In the past three years, have you consulted a health care professional for a routine checkup or physical exam?  Yes  No

9. Other than previously disclosed, are you using any prescription medications?  Yes  No

Name of medication

Reason

**1** [Add another medication](#)

Shows if "Yes"

10. Other than as indicated previously, in the past 5 years, have you been overnight in a hospital or other medical facility (excluding for childbirth, kidney stones, gallstones)?  Yes  No

Reason for your stay?

When did this occur?

Month  / Year

[Add another occurrence](#)

Shows if "Yes"

11. Do you plan on scheduling surgery or any other medical procedure in the next 6 months that would require an overnight hospital stay? (excluding for childbirth)  Yes  No

What surgery or medical procedure?

When is this scheduled?

Month  / Year

[Add another procedure](#)

Shows if "Yes"

[< Edit Previous](#) | [Save and Complete Later](#)

[Continue](#)

No.	Notes
<b>1</b>	<p>Multiple would show as:</p> <div style="border: 1px dashed #ccc; padding: 5px;"> <p><a href="#">Delete</a></p> <p>Name of medication</p> <input type="text"/></div> <div style="border: 1px dashed #ccc; padding: 5px;"> <p>Reason</p> <input type="text"/></div> <hr/> <div style="border: 1px dashed #ccc; padding: 5px;"> <p>Name of medication</p> <input type="text"/></div> <div style="border: 1px dashed #ccc; padding: 5px;"> <p>Reason</p> <input type="text"/></div> <p style="text-align: center;"><a href="#">Add another medication</a></p>



## About You

1. About You
2. Offer Selection
3. Payment
4. Beneficiaries
5. Agreements
Completion

### Your Family's Medical History

Which of the following conditions has any parent or sibling been diagnosed with **prior to age 60**? (check all that apply)

Cancer (do not include non-melanoma skin cancer)
 

- Breast
- Prostate
- Ovarian
- Colon
- Lung
- Melanoma

 Heart Attack/Coronary Artery Disease (Myocardial Infarction, Angina, other)
   
 Congestive heart failure
   
 Aneurysms
   
 Stroke
   
 Diabetes
   
 None of the above

Which of the following conditions has any parent or sibling been diagnosed with **at any age**? (check all that apply)

 Familial colon polyposis
   
 Huntington's chorea
   
 Polycystic kidney disease
   
 None of the above

In This Step

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

---

Find Answers

Chat Live with a Representative

Contact Metlife

**Please complete the following information for each family member diagnosed with any of the above conditions.** (If you have more than one family member with these conditions, add additional family members below.)

#### Family Member Details – [mother]

Which family member was diagnosed with a condition listed above?
  Mother
 Father
 Brother
 Sister

This family member is
  Living
 Deceased

Current age  If deceased, change to "Age at death"

Condition(s)
 

- [Condition 1]
- [Condition 2]
- [Condition 3]

OR

**Additional Question**

Have you had a colonoscopy in the past 3 years?
  Yes
 No
Shows if "familial colon polyposis" is selected

Were the results reported as normal?
  Yes
 No
Shows if prior answer = "yes"

[< Edit Previous](#) | [Save and Complete Later](#)
Continue

Shows if diagnosed = "Yes"

No.	Notes
1	Choices display if "Cancer" is checked.
2	When family member is selected, show it here. If sibling is chosen, show "Brother 1"... "Brother 2"...etc
3	Any conditions checked above will display.
4	Continue needs to be disabled until user clicks "All Family History" added
Note: If a condition selected above was not selected under a family member, error message must show	

## General Questions Section and Additional Reflexive Questions



# About You

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

**In This Step**

## General Questions

1. In the past three years, have you flown in a plane **other than as a passenger on a commercial airline** or do you have plans to do so in the next 12 months?  Yes  No

AVOC

2. In the past three years, have you participated in or do you plan to participate in any of the following? (check all that apply)

- Underwater sports – SCUBA Diving, skin diving or similar activities
- Racing sports – motorcycle, auto, motor boat or similar activities
- Sky sports – skydiving, hang gliding, parachuting, ballooning or similar activities
- Outdoor rock or mountain climbing or similar activities
- Bungee jumping or similar activities
- None of the above**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

- Find Answers
- Chat Live with a Representative

1 In the past 24 months have you participated in or do you plan in the next 12 months to participate in any of these activities outside of the United States/Canada?  Yes  No

*Shows if outside of US/Canada = "Yes"*

*Shows if any avocation is checked*

**Please be sure to complete Question 5 on this page**

DUI

3. Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past 5 years?  Yes  No

SUSP

4. Have you ever been convicted of or pled Guilty or No Contest to a felony?  Yes  No

FELONY

2 5. Have you traveled or resided outside of the U.S. or Canada in the past 24 months; or do you plan to travel or reside outside of the U.S. or Canada in the next 12 months?  Yes  No

TRAVEL

**You indicated above that you have or will participate in an activity outside of the US or Canada. Please complete this section.**

MIL

4 6. Are you a member of the military services?  Yes  No

5 7. Are you a dependent of a member of the military services?  Yes  No

[< Edit Previous](#) | [Save and Complete Later](#)

**Submit My Application**

No.	Notes
1	Displays if any of Question 2 are selected.
2	"Yes" is pre-selected if use chose "Yes" to "outside US/Canada" question 2. If user clicks no here, show 3
4	If "Yes", user must answer Military reflexive questions.
5	If this page is followed by "Existing Insurance" page, then button label should be "Continue"

Note: Only SCUBA triggers reflexive questions.

### Underwater Sports - Details

UW  
SPORTS

- Snorkeling
- SCUBA Diving
- Cave Diving
- Diving Alone
- Exploration of Sunken Wrecks
- Other
- Free/Breath Holding Diving
- Ice Diving
- Night Diving
- Rescue/Recovery
- Teaching
- Treasure Diving

Please enter details

Shows if "other" is selected

#### SCUBA

Maximum depth achieved  ft.

Total number of dives in past 12 months

Estimated number of dives in next 12 months

Are you certified?  Yes  No

Shows if "maximum depth is between 100 ft. and 150 ft."

Shows if "SCUBA" is selected

BUNGE  
E

### Bungee Jumping or Other Similar Activities

- Bungee Jumping

How many jumps per year  Shows if "bungee" is selected

- Similar Activity

Specify Sport/Activity

Frequency of participation in past 12 months  times

Estimated frequency of participation in next 12 months  times

Location(s) where each activity takes place

Shows if "similar activity" is selected

Describe safety equipment used

Club affiliation



# Racing Sports - Details

## Repeating Sections within Racing



See next page for details

Automobile  
Type of racing (check all that apply)

Drag

Track

Vehicle Details

Racing Method

Status

*Shows for each type of auto racing*

Shows if "automobile" is selected

- Go-kart
- Midget
- Modified
- Sports Car
- Stock

Motorcycle

Type of racing (check all that apply)

Drag

Track

Vehicle Details

Racing Method

Status

*Shows for each type of motorcycle racing*

Shows if "motorcycle" is selected

- Hill Climbing
- Scramble

Motorboat

Type of racing (check all that apply)

Modified

Vehicle Details

Racing Method

Status

*Shows for each type of motorcycle racing*

Shows if "motorcycle" is selected

- Unmodified
- Experimental
- Jet
- Unlimited Hydroplane
- Other

Please enter details

*Shows if "other" is selected*

## Repeating Sections within Racing

### Track

Type of track (check all that apply)

- Dirt  Hill Climb  
 Oval  Paved  
 Closed Circuit  Drag Strip  
 Other

Please enter details

Shows if "other" is selected

### Vehicle Details

Vehicle Details

Make and model

Displacement

Average Speed (MPH)

Maximum Speed (MPH)

### Racing Method

Racing Method

Vehicle versus vehicle racing

Number of races in the past 3 years

Estimated number of races in the next 12 months

Shows if "vehicle vs. vehicle" is selected

Vehicle versus clock

Number of races in the past 3 years

Estimated number of races in the next 12 months

Shows if "vehicle vs. clock" is selected

### Status

Status  Professional  Amateur

Name of affiliated association

AVOC

### Sky Sports - Details

Skydiving

Total number of dives, jumps or flights in the past 12 months

Estimated number of dives, jumps or flights in the next 12 months

Average height  ft.

Maximum height  ft.

Maximum duration  hours  minutes

Type of equipment  Assembled from a factory kit  
 Homemade  
 For experimental use  
 Purchased completely assembled

Status  Professional  Amateur

Name of affiliated association

Provide details of any stunt or exhibition jumps

Hang Gliding

Parachuting

Ballooning

Other

Please enter details

*Shows if "other" is selected*

Shows for each Sky Sport that is selected



### Outdoor Rock Climbing - Details

Specify Sport/Activity

Location(s) where each activity takes place

Describe safety equipment used

Club affiliation

Frequency of participation in the past 12 months  times

Estimated frequency of participation in the next 12 months  times



Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past 5 years?

Yes  No

Please check all that apply:

Suspended or Revoked  DUI or DWI  Moving violations in the past 5 years

Shows if prior answer = "Yes"

DUI / DWI

How many times have you been convicted of DUI / DWI?

Shows for each occurrence

Occurrence 1 1

Date of DUI / DWI  /    
Location of Offense City  State   
Driver's License number involved

1 Section will show up for each number of occurrences entered.

Were there any other related charges?  Yes  No

Please provide details for related charge(s) below. Shows if penalty imposed = "Yes"

Related Charge 1 Delete 2

Date of Offense  /    
Location of Offense City  State   
Name of Court   
Location of Court City  State

2 If multiple related charges, delete function will appear next to added charged

What was the offense? (speeding, reckless driving, leaving the scene of an accident, vehicular homicide, other)

Was any penalty imposed?  Yes  No

Please provide details  Shows if penalty imposed = "Yes"

3 Add another related charge

Shows if related charges = "Yes"

3 If user clicks, "Add another related charge", the section in red repeats with section title "Related Charge <#>"

Were there any accident(s) involved?  Yes  No

Were there damages to persons, property, or both?  Yes  No

Please select  Persons  Property  Both Shows if damages = "Yes"

Were there any fatalities involved?  Yes  No Shows if damages = "Persons" or "Both"

Please provide results of any legal proceedings

Shows if accidents = "Yes"

Has your license been suspended?  Yes  No

Current status  4 Shows if suspended = "Yes"

Please provide details  Shows if status = "Other"

4 Active  
Inactive  
Suspended  
Revoked  
Other

What were you under the influence of?  Drugs  Alcohol  Both

Describe your current alcohol consumption

How often do you drink alcohol? (e.g., "3 times per day", "15 times per month")

times per  5

How many drinks do you have on a typical day when you are drinking?

In the past 3 months how often did you have more than 4 drinks in one day?  times 6

Describe your past alcohol consumption around the time of your DUI/DWI

How often did you drink alcohol? (e.g., "3 times per day", "15 times per month")

times per  5

How many drinks did you have on a typical day when you were drinking?

In a typical 12 month period, how often did you have more than 4 drinks in one day?  times 6

Are you currently in a support group?  Yes  No

Shows if influence = "alcohol" or "both"

5 Day  
Week  
Month

6 (Hover to define "drink" 12 oz bottle/can beer, 1 oz hard alcohol, glass of wine)

Shows if "DUI or DWI" is selected

General – Suspended or Revoked



Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past 5 years?

Yes  No

Please check all that apply:

Suspended or Revoked  DUI or DWI  Moving violations in the past 5 years

Shows if prior answer = "Yes"

**Suspended or Revoked**

Date of Offense  /  /

Location of Offense City  State

Name of Court  (e.g., Middlesex Superior Court)

Location of Court City  State

What was the offense? (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)

Was any penalty imposed?  Yes  No  
Please provide details  fine, citation, imprisonment, other

Were there any other related charges?  Yes  No

Please provide details for related charge(s) below.

**Related Charge 1** [Delete](#)

Date of Offense  /  /

Location of Offense City  State

Name of Court

Location of Court City  State

What was the offense? (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)

Was any penalty imposed?  Yes  No  
Please provide details  fine, citation, imprisonment, other

[Add another related charge](#)

Were there any accident(s) involved?  Yes  No

Were there damages to persons, property, or both?  Yes  No

Please select  Person(s)  Property  Both

Were there any fatalities involved?  Yes  No

Please provide results of any legal proceedings

Shows if "Suspended or Revoked" is selected

1 If user clicks, "Add another related charge", the section in red repeats with section title "Related Charge <#>"

2 If multiple related charges, delete function will appear next to added charged

Shows if related charges = "Yes"

Shows if penalty imposed = "Yes"

Shows if accidents = "Yes"

Shows if damages = "Yes"

Shows if damages = "Persons" or "Both"

General – Felony  
General – Military

**FELONY**

Have you ever been convicted of or pled Guilty or No Contest to a felony?  Yes  No

Are you currently incarcerated?  Yes  No

Are you currently on parole or probation?  Yes  No

Was a weapon used in the commission of the felony?  Yes  No

Date of Conviction  /

Location of Offense City  State

Name of Court (e.g., Cook County Superior Court)

Location of Court City  State

What charges were you convicted of?

Was any penalty imposed?  Yes  No

Please provide details  *Shows if penalty imposed = "Yes"*

**MIL**

Are you a member of the military services?  Yes  No

Do you serve in any of these special forces?  Yes  No

- Navy SEALs
- Air Force Special Forces
- Army Rangers
- Delta Force
- Army Special Forces

What is your current pay grade?  E1 thru E4  Higher than E4

Are you being deployed abroad in the next 12 months?  Yes  No  Unknown

Please provide details (When, where and what capacity?)  *Shows if deployed = "Yes"*



Have you traveled or resided outside the U.S. or Canada in the past 24 months;  Yes  No or you plan to travel or reside outside the U.S. or Canada in the next 12 months?

Please select the countries that you visited or plan to visit. [How do I do this?](#)

Angola Austria Australia Bolivia Brazil	<input type="button" value="↑"/> <input type="button" value="☰"/> <input type="button" value="&gt;"/> <input type="button" value="&lt;"/> <input type="button" value="↓"/>	Argentina Israel Sweden
---	--	-------------------------------

Please provide details for the countries listed below.

**Sweden** *(Example of what shows for "A" countries)*

Duration  weeks

Please select one of the following statements:

This trip was in the past  This trip is in the future

Purpose of trip  Business  Leisure

**Argentina** *(Example of what shows for "B" & "C" countries)*

Duration  weeks

Please select one of the following statements:

This trip was in the past  This trip is in the future

Purpose of trip  Business  Leisure

Do you plan to participate in any missionary, journalistic, diplomatic or medical work?  Yes  No

What cities/regions of this country will you be visiting?

What activities have you planned while visiting this country?

Do you plan to visit non-urban areas?  Yes  No

Will you consider visiting war zones or hazardous areas of this country?  Yes  No

What is the availability of medical facilities, if needed?

What type of transportation will you use for travel to and from the area?

Shows if "future"

Shows if "Duration" is > 12 weeks

Israel (Example of what shows for "D" countries)

Duration  weeks

Please select one of the following statements:

- This trip was in the past
- This trip is in the future

Purpose of trip  Business  Leisure

Please answer the below questions to the best of your abilities.

What cities/regions of this country will you be visiting?

What activities have you planned while visiting this country?

Will you be attending a conference / seminar sponsored by a corporation, foundation, or industry group or something similar?  Yes  No

Will you be staying at an all-inclusive resort?  Yes  No

What is the name of the resort?  Shows if resort = "yes"

What type of accommodations will you stay in?

Do you plan to visit non-urban areas?  Yes  No

Will you consider visiting war zones or hazardous areas of this country?  Yes  No

Will you be going on an expedition/safari?  Yes  No

What is the availability of medical facilities, if needed?

What type of transportation will you use for travel to and from the area?

Will you be travelling with a group?  Yes  No

What travel company is hosting the trip?

How large is the group?

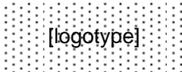
Are there any special security arrangements to help ensure the group's safety?  Yes  No

Shows if "future"

Shows if "Duration" is = or < 4 weeks

Shows if group = "yes"

PAYMENT



[logotype]

# Payment

- About You
- Payment
- Beneficiaries
- Agreement
- Completion

Go to:

## Payment Method

Existing Electronic Payment Number

[ACCOUNT NUMBER]

Billing information – Existing MIDA\$ Account has been indicated during EOT

- Choices are:
- Electronic Funds Transfer/EFT
  - Direct Bill/Check
  - Existing Electronic Payment Number

How often do you want to make your payments?

- Monthly, Quarterly, Semi-annually, Annually

Amount Collected with Application [\$xxx] via check

(Must be at least 1/12 of an annual premium.)

Amount agent collected during EOT

Save & Exit

Save

Save & Continue

[logotype]

Calculators & Tools

External Sites

[PIN]

## Payment

About You | Payment | Beneficiaries | Agreement | **Completion**

Payment method:

Choices are:  
Electronic Funds Transfer/EFT  
Direct Bill/Check  
Existing Electronic Payment Number

Who is paying for this policy?

Choices are: Spouse, Parent, Grandparent, Domestic Partner/Civil Union, Guardian, Child or Employer

How often do you want to make your payments?

Monthly  
Quarterly  
Semi-annually  
Annually

Bank Account Type  Checking  Savings

### Account Information

Payor Name   
Bank Routing Number  Repeat Routing Number  
Financial Institution   
Bank Account Number  Repeat Account Number

If self, pre-populate with applicant's name, but editable.

Bank Routing Number, Financial Institution, and Bank Account Number fields only show for payor = "Self"

Please enter billing address if different from your Residence Address

Address   
City  State  Zip

If relationship is "self" or "spouse", then billing address shows applicant's residence.  
If relationship is other than "self" or "spouse", then fields will be blank and instruction will read: "Please enter billing address:"

Amount Collected with Application  via check

(Must be at least 1/12 of an annual premium.)

Amount agent collected during EOT

Debit will take place this date:

Shows date only, not month

Save & Exit

Save

Save & Continue

continues on next page ...

# Payment

- About You
- Payment
- Beneficiaries
- Agreement
- Completion

Go to:

Payment method:

Choices are:  
 Electronic Funds Transfer/EFT  
 Direct Bill/Check  
 Existing Electronic Payment Number

How often do you want to make your payments?

Quarterly, Semi-annually, Annually

Who is paying for this policy?

Payor Name

Please enter billing address if different from your Residence Address

Address

City  State  Zip

Choices are: Spouse, Parent,  
 Grandparent, Domestic Partner/Civil  
 Union, Guardian, Child or Employer ...

Payor Name

Address

City  State  Zip

Section shows if payor = "Self" or  
 "Spouse". If "Self", pre-populate name  
 and address. If "Spouse", just pre-  
 populate address

Amount Collected with Application [\$xxx] via "check".

(Must be at least 1/12 of an annual premium.)

Section shows if payor = other than "Self"  
 or "Spouse"

Amount agent collected during EOT

Save & Exit

Save

Save & Continue



# Payment Information

- 1. Profile
- 2. Medical & Risk
- 3. Offer Selection
- 4. Beneficiary
- 5. Payment
- 6. Agreements
- 7. Completion

Who is paying for this policy? Self 1

Payor Name

Payment Method Debit Card/Credit Card

American Express  Visa  Mastercard  Discover

Account Number

Expiration ▼ / ▼

CCV#

Please enter billing address if different from your Residence Address

Address

City  State ▼ Zip

**Continue**

**In This Step**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

**Find Answers**

**Chat Live with a Representative**

**Contact MetLife**

Description
Payment by Credit Card

No.	Notes
1	Choices are: Spouse, Parent, Grandparent, Domestic Partner, Guardian, Child or Employer If "Self", default applicant name as cardholder name.

## BENEFICIARIES



# Choose Your Beneficiaries

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

## Primary Beneficiaries

Beneficiary Type  Individual  Trust

First Name

Middle Name

Last Name

Relationship

Date of Birth  /  /

% of Proceeds  %

### Allocation for Primary Beneficiaries

Name	Relationship	Date of Birth	Percentage
Mary Smith	Spouse	2/16/1972	<input type="text" value="100"/> %
<b>Primary Total:</b>			100%

## Contingent (Secondary) Beneficiaries

Same fields above will display here

### Contingent (Secondary) Beneficiaries

Include all living and future natural and adopted children as Contingent Beneficiaries. (Please add all living children as contingent beneficiaries)

Name	Relationship	Date of Birth	Percentage
------	--------------	---------------	------------

**In This Step**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

**Find Answers**

**Chat Live with a Representative**

**Contact MetLife**

**Description**

User names their beneficiaries. Beneficiary is an individual in this example.

No.	Notes
1	<p>Message explaining the user user must add a primary first. Should appear as an overlay message for a few seconds then fade out..</p> <div style="border: 1px solid gray; padding: 5px; text-align: center;"> <p>Please add at least one primary beneficiary. You can update beneficiaries at any time in the future.</p> </div>



# Choose Your Beneficiaries

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements
- Completion

## Primary Beneficiaries

Beneficiary Type  Individual  Trust

Trust Name  **1**

This trust has a  SSN  TIN Enter (SSN)  **2**

Date Established  /  /  % of Proceeds  %

At least one trustee must be named.

Trustee Name

Address

City  State  Zip

[Add more / Edit trustees](#)

## Allocation for Primary Beneficiaries

Name	Relationship	Percentage
[name of trust]		100 %
<b>Primary Total:</b>		100%

## Contingent (Secondary) Beneficiaries

Same fields above will display here

## Contingent (Secondary) Beneficiaries

Include all living and future natural and adopted children as Contingent Beneficiaries. (Please add all living children as contingent beneficiaries)

Name	Relationship	Date of Birth	Percentage
------	--------------	---------------	------------

**Continue**

**In This Step**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

**Find Answers**

**Chat Live with a Representative**

**Contact MetLife**

Description
User names their beneficiaries. Beneficiary is a trust in this example.

No.	Notes
<b>1</b>	Default example text
<b>2</b>	SSN or TIN will show, depending on selection

## Agreements

# MetLife Agreements

- 1. About You
- 2. Offer Selection
- 3. Payment
- 4. Beneficiaries
- 5. Agreements**
- Completion

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Donec sapien nulla, iaculis ut, vehicula ut, ornare in, dui. Aliquam ornare.

**1** *Fraud warning for applicable states*

**Important Application Information** **2**  
[View document](#)

**Adverse**  
[View document](#)

**Life Insurance**  
[View document](#)

**(Agreement)**  
[View document](#)

**Bank Draft**  
[View document](#)

**Replacement Form (if applicable)** **3**  
[View document](#)

**I agree to all of the above**

Final list of agreements TBD by Legal

**In This Step**

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean pretium tristique sapien, faucibus pharetra sapien viverra in.

- Find Answers
- Chat Live with a Representative
- Contact MetLife

Description
User will need to agree to the required policies and terms (“eSignature page”).

No.	Notes
<b>1</b>	If applicable, respective fraud warning would appear based on applicant’s state (refer to application for states and warnings).
<b>2</b>	Clicking “View document” launches print-friendly version of documents
<b>3</b>	Completed replacement forms will be generated

SERFF Tracking Number: METD-126382418 State: Arkansas  
 Filing Company: MetLife Investors USA Insurance Company State Tracking Number: 44831  
 Company Tracking Number: EWEB-67-10  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -  
 Fixed/Indeterminate Premium  
 Product Name: Application for Life Insurance  
 Project Name/Number: Internet Term Life Insurance Application/EWEB-67-10

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/27/2010	Form	Application for Life Insurance	04/08/2010	EWEB-67-10 (Bracketed-AR,NM,OH,OK5).pdf (Superseded)

Application for Life Insurance

MetLife Investors USA Insurance Company (Referred to as "the Company".)

IS THIS APPLICATION BEING COMPLETED IN THE UNITED STATES?  Yes  No

SECTION I - About the Proposed Insured

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Country of Legal Residence \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-Mail \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Gender  Male  Female \_\_\_\_\_ Place of Birth (State/Country) \_\_\_\_\_ Social Security Number \_\_\_\_\_

U.S. Driver's License  Passport  State Issued ID  Employment Authorization Document (EAD) Card  
Issuer of ID \_\_\_\_\_ ID Number \_\_\_\_\_ Expiration Date (if any) \_\_\_\_\_

Are you a U.S. Citizen?  Yes  No

If NO, Country of Citizenship? \_\_\_\_\_

How long have you lived in the U.S.? \_\_\_\_\_

Do you have Permanent Resident status in the U.S.?  Yes  No

NON U.S. PERMANENT RESIDENTS ONLY - Country of Permanent Residence \_\_\_\_\_

Do you have a U.S. Visa?  Yes  No

If YES, U.S. Visa Type \_\_\_\_\_ Visa Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

If NO Visa, do you have an Employment Authorization Document (EAD) Card?  Yes  No

If YES, what is the EAD Class? \_\_\_\_\_

If NO EAD Card, do you have a Visa/Immigration application pending with the USCIS?  Yes  No

If YES, Application Number: \_\_\_\_\_

SECTION II - Employment

EMPLOYMENT STATUS:  Currently Employed  Student  Homemaker  Unemployed

Currently Employed:

Name of Employer \_\_\_\_\_

Work Address: City \_\_\_\_\_ State/Country \_\_\_\_\_

Position/Duties \_\_\_\_\_

Are you currently working and performing your usual job duties?  Yes  No

If YES, Annual Income: \$ \_\_\_\_\_

If NO, why are you unable to work?  Physical/Mental Impairment  Family Medical Leave

Physical/Mental Impairment:

Why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes  No  Unknown/Unsure

If YES, annual income prior to disability: \$ \_\_\_\_\_



If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Main Source of Income:

- Long Term Disability       Worker's Compensation       Charitable Organization       Government Assistance
- Social Security Disability       Savings/Investments       Short Term Disability       Family Members
- Other, please enter details. \_\_\_\_\_

**Family Medical Leave:**

This leave is related to:  Birth/Adoption       Family       Other

If **BIRTH/ADOPTION** or **FAMILY**, Annual Income: \$ \_\_\_\_\_

If **OTHER**, please answer the following questions:

Why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes       No       Unknown/Unsure

If **YES**, annual income prior to disability: \$ \_\_\_\_\_

If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Current Annual Income: \$ \_\_\_\_\_

Main Source of Income:

- Long Term Disability       Worker's Compensation       Charitable Organization       Government Assistance
- Social Security Disability       Savings/Investments       Short Term Disability       Family Members
- Other, please enter details. \_\_\_\_\_

**Student:**

Annual Income: \$ \_\_\_\_\_

What is the main source of your remaining support?

- Parent       Grandparent       Grants       Spouse/Civil Union/Domestic Partner
- Sibling       Savings/Investments       Student Loans
- Other, please enter details. \_\_\_\_\_

**Homemaker:**

Annual Household Income: \$ \_\_\_\_\_

What is the main source of your household income?

- Parent       Grandparent       Government Assistance/Social Security       Disability Income
- Sibling       Savings/Investments       Unemployment Benefits       Spouse/Civil Union/Domestic Partner
- Other, please enter details. \_\_\_\_\_

If **YES** to Disability Income, are you receiving disability income due to your personal disability?  Yes       No

If **YES**, why are you unable to work? \_\_\_\_\_

**Unemployed:**

What is the main source of your income?

- Parent       Grandparent       Government Assistance/Social Security       Disability Income
- Sibling       Savings/Investments       Unemployment Benefits       Spouse/Civil Union/Domestic Partner
- Other, please enter details. \_\_\_\_\_

Annual Income: \$ \_\_\_\_\_

If **YES** to Disability Income, are you receiving disability income due to your personal disability?  Yes       No

If **YES**, why are you unable to work? \_\_\_\_\_

Do you expect to return to work within [six] months?  Yes       No       Unknown/Unsure

If **YES**, annual income prior to disability: \$ \_\_\_\_\_

Have you been previously employed?  Yes       No



If **YES**, please answer the following questions.

What was your last date of employment? \_\_\_\_\_

What was the name of your employer? \_\_\_\_\_

What was your position/duties? \_\_\_\_\_

How long did you work there? \_\_\_\_\_

What was your annual income with your former employer? \_\_\_\_\_

If **NO**, are you a student?

Yes  No

Will you pay for this life insurance policy with your earned income (for example, annual salary)?

Yes  No

If **NO**, what is the source of the payments for this life insurance policy?

- Savings/Investments     Grandparent     Parent     Spouse/Civil Union/Domestic Partner
- Sibling     Loans     Use of Values from another Life Insurance/Annuity Contract
- Other - Please enter details: \_\_\_\_\_

### SECTION III - Beneficiary

Beneficiary Type:     Individual     Trust

Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured (You)	Percentage of Proceeds (if not equal)
Primary				
<input type="checkbox"/> Primary				
<input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary				
<input type="checkbox"/> Contingent				

Check here to include all living and future natural or adopted children as Contingent Beneficiaries. (Name all living children above.)

Trust Name \_\_\_\_\_

Social Security Number/TIN \_\_\_\_\_ Date Established \_\_\_\_\_ % of Proceeds \_\_\_\_\_

Beneficiary Type     Primary     Contingent

Trustee Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### SECTION IV - Existing or Applied-for Coverage

1. Do you have any existing or applied-for life insurance or annuities with this or any other company?     Yes     No

If **YES**, please provide details about your existing **Life** insurance and any **Life** insurance policies you have applied for.

Company	Amount of Insurance	Status
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For
		<input type="checkbox"/> Existing <input type="checkbox"/> Applied-For

2. By applying for this life insurance policy, do you plan to cancel, withdraw money from, take a loan from, reduce premium payments for, or otherwise change an existing life insurance policy or annuity?     Yes     No



3. Have you ever had an application for life, disability income or health insurance declined, postponed (temporarily declined), issued/offered with an increase in premium or modified due to risk factors?  Yes  No

If **YES**, please fill in the details below:

Type of Insurance: Life/Health/ Disability	Action Taken (Declined, Postponed, Increased Premium, Modified)	Reason for Action (Medical, occupation, foreign travel, residence, aviation, hazardous sports, driving, other, unknown/unsure)	Year Action Occurred

**SECTION V - Payment Information**

Who is paying for this policy?  Self  Other  
 If Other, please answer the following: Payor Name \_\_\_\_\_ Relationship to Proposed Insured (You) \_\_\_\_\_

Please enter Billing Address if different from your Residence Address.  
 Billing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAYMENT METHOD** (Check the appropriate ONE.)

[Electronic Funds Transfer]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly  Monthly   
 Existing Electronic Payment Number \_\_\_\_\_  
 If you are the bank account holder, please fill out the following bank account information. If the Other Payor is the bank account holder, the Other Payor must complete the Electronic Payment (EP) Account Agreement form.  
 Name of Financial Institution: \_\_\_\_\_  
 Bank Account Type:  Checking  Savings  
 Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_  
 Debit will take place this date: \_\_\_\_\_  
 Amount Collected with Application: \_\_\_\_\_ (Must be at least 1/12 of an annual premium.)

[Direct Bill/Check]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly   
 Amount Collected with Application: \_\_\_\_\_ (Must be at least 1/12 of an annual premium.)

[Debit/Credit Card]  
 How often do you want to make your payments?  Annually  Semi-Annually  Quarterly  Monthly   
 [Visa]  [MasterCard]  [American Express]  [Discover]  
 Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ [CCV #:] \_\_\_\_\_

**SECTION VI - General Questions**

1. In the past [three] years, have you flown in a plane other than as a passenger on a commercial airline or do you have plans to do so in the next 12 months?  Yes  No

2. In the past [three] years, have you participated in or do you plan to participate in **any** of the following? Check **ALL** that apply.

Underwater sports - SCUBA diving, skin diving, or similar activities  Outdoor rock or mountain climbing or similar activities  
 Racing sports - motorcycle, auto, motor boat or similar activities  Bungee jumping or similar activities  
 Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities  
 None of the Above

In the past 24 months have you participated in or do you plan in the next 12 months to participate in any of these activities outside of the United States/Canada?  Yes  No





3. Have you ever been convicted of or pled Guilty or No Contest to a felony?

Yes  No

If **YES**, please answer the following:

Are you currently incarcerated?

Yes  No

Are you currently on parole or probation?

Yes  No

Was a weapon used in the commission of the felony?

Yes  No

Date of Conviction: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What charges were you convicted of? \_\_\_\_\_

Was any penalty imposed?

Yes  No

If **YES**, please provide details. \_\_\_\_\_

4. Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past [five] years?

Yes  No

If **YES** - Please check **ALL** that apply:

Suspended/Revoked  DUI or DWI  Moving Violations in the past [five] years

**Suspended/Revoked:**

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?

Was any penalty imposed?

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any other related charges?

Yes  No

If **YES**, please provide details for related charges below.

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?

Was any penalty imposed?

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any accident(s) involved?

Yes  No

If **YES**, please answer the following:

Were there damages to persons, property, or both?

Yes  No

If **YES**, please select:

Person(s)  Property  Both

Were there any fatalities involved?

Yes  No

Please provide results of any legal proceedings. \_\_\_\_\_



**DUI or DWI:**

How many times have you been convicted of DUI/DWI? \_\_\_\_\_

Date of DUI/DWI: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Driver's License Number Involved: \_\_\_\_\_

Were there any other related charges?  Yes  No

If **YES**, please provide details for related charges below.

Date of Offense: \_\_\_\_\_ Location of Offense: City \_\_\_\_\_ State \_\_\_\_\_

Name of Court: \_\_\_\_\_

Location of Court: City \_\_\_\_\_ State \_\_\_\_\_

What was the offense (speeding, reckless driving, leaving the scene of an accident, vehicular homicide, other)?  
\_\_\_\_\_

Was any penalty imposed?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

Were there any accident(s) involved?  Yes  No

If **YES**, please answer the following:

Were there damages to persons, property, or both?  Yes  No

If **YES**, please select:  Person(s)  Property  Both

Were there any fatalities involved?  Yes  No

Please provide results of any legal proceedings.  
\_\_\_\_\_

Has your license been suspended?  Yes  No

If **YES**, please provide current status:  Active  Inactive  Suspended  Revoked  Other

If **Other**, please provide details. \_\_\_\_\_

What were you under the influence of?  Drugs  Alcohol  Both

**Alcohol/Both**

A. Describe your current alcohol consumption:

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months how often did you have more than four drinks in one day? \_\_\_\_\_

B. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? \_\_\_\_\_

How many drinks did you have on a typical day when you were drinking? \_\_\_\_\_

In a typical 12 month period, how often did you have more than four drinks in one day? \_\_\_\_\_

C. Are you currently in a support group?  Yes  No



5. Have you **traveled** or **resided** outside of the U.S. or Canada in the past 24 months; or do you plan to **travel** or **reside** outside of the U.S or Canada in the next 12 months?

Yes  No

If **YES**, please provide details.

Past	Future	Duration (weeks)	Countries	Purpose
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

If **YES**, please provide the information below for planned future travel.

- A. Do you plan to participate in any missionary, journalistic, diplomatic, or medical work?  Yes  No
- B. What cities/regions of this country will you be visiting? \_\_\_\_\_
- C. What activities have you planned while visiting this country? \_\_\_\_\_
- D. Do you plan to visit non-urban areas?  Yes  No
- E. Will you consider visiting war zones or hazardous areas of this country?  Yes  No
- F. What is the availability of medical facilities, if needed? \_\_\_\_\_
- G. What type of transportation will you use for travel to and from the area? \_\_\_\_\_
- H. Will you be attending a conference/seminar sponsored by a corporation, foundation or industry group or something similar?  Yes  No
- I. Will you be staying at an all-inclusive resort?  Yes  No
- J. What is the name of the resort? \_\_\_\_\_
- K. What type of accommodations will you stay in? \_\_\_\_\_
- L. Will you be going on an expedition/safari?  Yes  No
- M. Will you be traveling with a group?  Yes  No
- N. What travel company is hosting the trip? \_\_\_\_\_
- O. How large is the group? \_\_\_\_\_
- P. Are there any special security arrangements to help ensure the group's safety?  Yes  No

6. In the past [five] years, have you used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)?

Yes  No

If **YES**, type of product used:

Product(s)	Date Last Used

If Cigars, number per year: \_\_\_\_\_



**SECTION VII - Health Questions**

1. Height (ft. in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

2. Have you ever been diagnosed, received treatment, or consulted with a health care professional for any of the following? Check **ALL** that apply.

- High Blood Pressure     High Cholesterol     Cancer     Diabetes     Rheumatoid Arthritis     Systemic Lupus
- Neurological Disorder (Mental Retardation, Multiple Sclerosis, Paralysis, Seizures, Other) (excluding headaches and migraine headaches)
- Emotional or Psychological Disorder (Anxiety, Depression, Eating Disorder, Other)
- None of the Above

**HIGH BLOOD PRESSURE:**

In the past [10] years, have you been hospitalized for high blood pressure?

Yes     No

If **NO**, please answer the following.

A. Are you taking any medications for high blood pressure?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

B. Have you had your blood pressure taken in the past [12] months?

Yes     No

If **YES**, do you remember your most recent blood pressure reading?

Yes     No

If **YES**, what was the reading? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**HIGH CHOLESTEROL:**

A. Have you had your cholesterol tested in the past [12] months?

Yes     No

If **YES**, please answer the following.

Do you know the results of your most recent cholesterol reading?

Yes     No

If **YES**, please enter the reading: \_\_\_\_\_

B. Are you taking any medications for cholesterol?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**CANCER:**

A. Are you currently receiving any treatment for the cancer?

Yes     No

B. What was the location and type of cancer?

Location \_\_\_\_\_ Type \_\_\_\_\_  Check if Unknown

C. When was the cancer diagnosed? Date \_\_\_\_\_



D. What was the stage of cancer you had:

- Stage 0     Stage 1     Stage 2     Stage 3     Stage 4     Unknown

E. Had the cancer spread to your lymph nodes or any other site?

Yes     No

F. What treatments did you receive for the cancer? Check **ALL** that apply.

- Chemotherapy     Radiation     Surgery
- Other, please explain \_\_\_\_\_

G. When was the treatment completed? Date \_\_\_\_\_

Yes     No

H. Has there ever been a recurrence of the cancer?

Yes     No

I. Has any other treatment, surgery, testing or other follow-up (other than your regular check-up) been discussed, suggested or planned for the cancer?

Yes     No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**DIABETES:**

A. Did you have diabetes only during pregnancy?

Yes     No

If **YES**, please complete the following.

Are you currently pregnant?

Yes     No

If **NO**, please complete the following.

Are you currently being treated for diabetes?

Yes     No

If **NO**, please complete the following.

Has your blood sugar returned to normal?

Yes     No

B. In the past [five] years, have you been hospitalized for diabetes?

Yes     No

C. Have you ever been diagnosed as having kidney disease or protein in your urine?

Yes     No

D. Have you ever been diagnosed as having Retinopathy or Diabetic related eye problems?

Yes     No

E. Have you ever been diagnosed as having Diabetic related neuropathy?

Yes     No

F. Have you had any other complications of diabetes (skin infections, poor circulation, other)?

Yes     No

If **YES**, please provide details. \_\_\_\_\_

G. How old were you when the diabetes was diagnosed? \_\_\_\_\_

H. Have you had a check-up with a health care professional for diabetes in the past [12] months?

Yes     No

I. Are you taking any medications for diabetes?

Yes     No

If **YES**, please list medications. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**RHEUMATOID ARTHRITIS:**

A. Have you been diagnosed as having heart, lung, or kidney problems related to rheumatoid arthritis?  Yes  No

B. Are you taking any medications for rheumatoid arthritis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

Have you had any changes to your medications in the past [12] months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

C. Have you had any joints replaced?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

D. Are you limited in any activities due to rheumatoid arthritis?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to rheumatoid arthritis? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**NEUROLOGICAL DISORDER:**

If **YES**, what was the diagnosis? Check **ALL** that apply.

Mental Retardation  Multiple Sclerosis  Paralysis  Seizures

Other - Please answer the questions in **Section X - Other**.

**Multiple Sclerosis:**

A. Were you diagnosed with multiple sclerosis in the past [12] months?  Yes  No

B. How old were you when the multiple sclerosis was diagnosed? \_\_\_\_\_

C. Have you been hospitalized in the past [three] years for multiple sclerosis?  Yes  No

D. Are you able to walk?  Yes  No

[If **YES**, do you require an aid (cane, walker, other)?]   Yes  No

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to multiple sclerosis? \_\_\_\_\_

F. Are you currently taking or have you taken in the past 12 months any medications for multiple sclerosis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

G. In the past [24] months have you had any symptoms of multiple sclerosis?  Yes  No

If **YES**, please describe your symptoms. \_\_\_\_\_ ]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**Paralysis:**

- A. Was this Bell's Palsy only?  Yes  No
- B. Was the onset of the paralysis in the past 12 months?  Yes  No
- C. Was the paralysis caused by trauma or an accident?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

D. What part of your body is affected by this condition (one arm, both arms, one leg, both legs, other)?  
\_\_\_\_\_ ]

E. Are you able to walk?  Yes  No

If **YES**, do you require an aid (cane, walker, other)?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

F. Do you use a urinary catheter?  Yes  No

G. Do you have any kidney impairment other than kidney stones?  Yes  No

H. Do you have any complications such as infections, skin ulcers or kidney stones?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

If **YES**, are you receiving any treatment for the complications?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Seizures:**

A. What type of seizures do you have? Check **ALL** that apply.

- Tonic-clonic/Grand mal
- Absence/Petit mal
- Focal/Partial
- Febrile
- Unknown

Other - Please provide details. \_\_\_\_\_

B. Is there a known cause for the seizures?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

C. How old were you when the seizures were diagnosed? \_\_\_\_\_

D. Was your last seizure in the past 12 months?  Yes  No

If **YES**, how many seizures did you have in the past 12 months? \_\_\_\_\_ ]

If **NO**, date of last seizure: \_\_\_\_\_ ]

E. Are you taking any medications for seizures?  Yes  No

If **YES**, please list medications. \_\_\_\_\_ ]

F. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]

G. Have you had any surgery for seizures?  Yes  No

If **YES**, date of surgery? \_\_\_\_\_ ]

H. Are you prevented from holding a driver's license or are your activities restricted in any other way due to seizures?  Yes  No

If **YES**, please provide details. \_\_\_\_\_ ]



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**EMOTIONAL OR PSYCHOLOGICAL DISORDER:**

If **YES**, what was the diagnosis? Check **ALL** that apply.

Yes  No

Anxiety  Depression  Eating Disorder  Other - Please answer the questions in **Section X - Other**.

**Anxiety:**

A. Have you been hospitalized in the past [five] years for anxiety?  Yes  No

Yes  No

B. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anxiety? \_\_\_\_\_

C. Have you ever attempted to end your life?  Yes  No

Yes  No

D. Are you taking any medications for anxiety?  Yes  No

Yes  No

If **YES**, please list medications. \_\_\_\_\_

E. Have you had any changes to your medications in the past 12 months?  Yes  No

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Depression:**

A. Have you ever been diagnosed with bipolar disease or manic depression?  Yes  No

Yes  No

B. Have you been hospitalized in the past [five] years for depression?  Yes  No

Yes  No

C. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to depression? \_\_\_\_\_

D. Have you ever attempted to end your life?  Yes  No

Yes  No

E. Are you taking any medications for depression?  Yes  No

Yes  No

If **YES**, please list medications. \_\_\_\_\_

F. Have you had any changes to your medications in the past 12 months?  Yes  No

Yes  No

If **YES**, please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



**Eating Disorder:**

If **YES**, what type of eating disorder? Check **ALL** that apply.

- Anorexia Nervosa
- Bulimia
- Other - Please provide details. \_\_\_\_\_

A. Are you currently in remission?

Yes  No

If **YES**, how long have you been in remission? \_\_\_\_\_

B. How old were you when this eating disorder began? \_\_\_\_\_

C. Have you ever had any relapses (eating disorder went into remission but then recurred)?

Yes  No

If **YES**, how many relapses have you had? \_\_\_\_\_

D. How long have you been at your current weight? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

3. Other than as indicated above, have you ever had any disease or disorder of any of the following? Check **ALL** that apply.

- Heart (Congenital Heart Disease, Coronary Artery Disease, Heart Attack, Heart Murmur, Valvular Heart Disease, Other)
- Arteries / Veins (Aneurysm, Carotid Artery Disease, Stroke, Transient Ischemic Attacks (TIA), Other) (excluding varicose veins)
- Kidneys (Glomerulonephritis, Kidney Failure, Kidney Transplant, Nephritis, Nephrotic Syndrome, Polycystic Kidney Disease, Pylonephritis, Other) (excluding kidney stones)
- Lungs / Respiratory System (Asthma, Chronic Bronchitis, Cystic Fibrosis, Sleep Apnea, Other) (excluding colds)
- Liver (Cirrhosis, Hepatitis, Other)  Blood (Anemia, Leukemia, Other)
- Gastrointestinal/Digestive System (Crohn's Disease, Pancreatitis, Ulcerative Colitis, Other)
- None of the Above

**HEART:**

What was the diagnosis? Check **ALL** that apply.

- Congenital Heart Disease
- Heart Attack
- Valvular Heart Disease
- Coronary Artery Disease
- Heart Murmur
- Other - Please answer the questions in **Section X - Other**.

**Congenital Heart Disease:**

Which of the following have you ever had? Check **ALL** that apply.

- Atrial Septal Defect (ASD)
- Ebstein's Anomaly
- Tetralogy of Fallot
- Unknown
- Bicuspid Aortic Valve
- Hypoplastic Left Heart Syndrome
- Transposition of the Great Arteries
- Coarctation of the Aorta
- Patent Ductus Arteriosus (PDA)
- Tricuspid Atresia
- Dextrocardia
- Pulmonary Atresia
- Ventricular Septal Defect (VSD)
- Other - Please provide details. \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_



Atrial Septal Defect (ASD):

A. Was the ASD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

Bicuspid Aortic Valve:

A. Have you had any surgery or is surgery planned or recommended by a health care professional?

Yes  No

B. Do you have any symptoms related to heart disease?

Yes  No

C. Do you have any associated aortic stenosis or aortic insufficiency?

Yes  No

Unknown

D. Do you have any other heart or blood vessel abnormality?

Yes  No

E. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

G. Do you have any physical limitations due to heart disease?

Yes  No

Dextrocardia:

A. Do you have any other heart or other congenital abnormalities?

Yes  No

B. Do you have any physical limitations due to the dextrocardia?

Yes  No

C. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

Patent Ductus Arteriosus (PDA):

A. Was the PDA surgically corrected before age five?

Yes  No

If **NO**, did the PDA close on its own before age five?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No



**Heart Murmur:**

Was it described as or diagnosed as: Check **ALL** that apply.

- Functional, Innocent, or a Flow Murmur
- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Atrial Septal Defect (ASD)
- Unknown
- Mitral Stenosis
- Mitral Valve Prolapse
- Mitral Insufficiency (Regurgitation)
- Pulmonary Insufficiency (Regurgitation)
- Other - Please provide details. \_\_\_\_\_
- Tricuspid Insufficiency (Regurgitation)
- Pulmonary Stenosis
- Tricuspid Stenosis
- Ventricular Septal Defect (VSD)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Functional, Innocent, or a Flow Murmur:

- A. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- B. Do you have any physical limitations due to heart disease?  Yes  No
- C. Have you been advised to have a follow-up echocardiogram?  Yes  No

Atrial Septal Defect (ASD):

- A. Was the ASD surgically corrected?  Yes  No
- If **YES**, was the surgery prior to age five?  Yes  No
- If **NO**, is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- C. Do you have any physical limitations due to heart disease?  Yes  No
- D. Do you have any other heart abnormality?  Yes  No

Mitral Insufficiency (Regurgitation):

- A. Do you have any shortness of breath or limited exercise tolerance related to mitral insufficiency (regurgitation)?  Yes  No
- B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No
- C. Has the mitral insufficiency (regurgitation) been described as:
  - Trivial/Slight    Mild    Moderate    Severe    Unknown
- D. Do you have any other heart abnormality including any other valvular disease?  Yes  No
- E. Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?  Yes  No
- G. Do you have any physical limitations due to heart disease?  Yes  No
- H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years?  Yes  No  Unknown

Mitral Valve Prolapse:

- A. Is any surgery planned or has surgery been recommended by a health care professional?  Yes  No
- B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?  Yes  No
- C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?  Yes  No



D. Do you have any mitral insufficiency (regurgitation)?

Yes  No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

F. Do you have any physical limitations due to heart disease?

Yes  No

G. Do you have any other heart abnormality including any other valvular disease?

Yes  No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes  No

If **YES**, was the surgery prior to age five?

Yes  No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

C. Do you have any physical limitations due to heart disease?

Yes  No

D. Do you have any other heart abnormality?

Yes  No

**Valvular Heart Disease:**

Have you had valve surgery?

Yes  No

Which of the following valve diseases do you have? Check **ALL** that apply.

- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Mitral Stenosis
- Unknown
- Mitral Insufficiency (Regurgitation)
- Mitral Valve Prolapse
- Pulmonary Stenosis
- Other - Please provide details. \_\_\_\_\_
- Pulmonary Insufficiency (Regurgitation)
- Tricuspid Stenosis
- Tricuspid Insufficiency (Regurgitation)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Mitral Insufficiency (Regurgitation):

A. Do you have any shortness of breath or limited exercise tolerance related to the mitral insufficiency (regurgitation)?

Yes  No

B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No

C. Has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

D. Do you have any other heart abnormality including any other valvular disease?

Yes  No

E. Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

G. Do you have any physical limitations due to heart disease?

Yes  No

H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years?

Yes  No  
 Unknown

Mitral Valve Prolapse:

A. Is any surgery planned or has surgery been recommended by a health care professional?

Yes  No

B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?

Yes  No

C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes  No



D. Do you have any mitral insufficiency (regurgitation)?

Yes  No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight  Mild  Moderate  Severe  Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes  No

F. Do you have any physical limitations due to heart disease?

Yes  No

G. Do you have any other heart abnormality including any other valvular disease?

Yes  No

**ARTERIES/VEINS:**

What was the diagnosis? Check **ALL** that apply.

Aneurysm  Carotid Artery Disease  Stroke  Transient Ischemic Attacks (TIAs)  
 Other - Please answer the questions in **Section X - Other**.

**LUNG/RESPIRATORY SYSTEM:**

What was the diagnosis? Check **ALL** that apply.

Asthma  Chronic Bronchitis  Cystic Fibrosis  Sleep Apnea  
 Other - Please answer the questions in **Section X - Other**.

**Asthma:**

A. Have you been hospitalized overnight for asthma in the past [24] months?

Yes  No

B. Have you visited the emergency room or an urgent care center in the past [24] months related to asthma?

Yes  No

If **YES**, how many times have you been to the emergency room or an urgent care center related to asthma in the past [24] months? \_\_\_\_\_

When was the last time you were in an emergency room or an urgent care center related to asthma? \_\_\_\_\_

C. Have you had asthma symptoms in the past [six] months (other than with exercise)?

Yes  No

If **YES**, how often do your symptoms occur? \_\_\_\_\_ per week

D. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to asthma? \_\_\_\_\_

E. Other than inhalers, are you currently taking any medications for asthma?

Yes  No

If **YES**, please list medications. \_\_\_\_\_

F. Have you taken oral steroid pills in the past [12] months for asthma?

Yes  No

If **YES**, how many episodes/attacks of asthma required taking oral steroid pills in the past [12] months? \_\_\_\_\_

Were any courses of steroids longer than a continuous two week period? \_\_\_\_\_

Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Chronic Bronchitis:**

A. Have you been hospitalized for chronic bronchitis in the past [three] years?

Yes  No

B. Do you have three or more attacks of bronchitis per year?

Yes  No

C. Do you have complete recovery (no symptoms) between episodes of bronchitis?

Yes  No

D. Do you have any ongoing underlying lung disease other than asthma?

Yes  No

If **YES**, please provide details. \_\_\_\_\_



E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to bronchitis? \_\_\_\_\_

F. Are you taking any medications for chronic bronchitis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

G. Have you required oral steroid pills in the past [12] months for bronchitis?  Yes  No

If **YES**, how many episodes of bronchitis have required taking oral steroid pills in the past [12] months? \_\_\_\_\_

Were any courses of steroids longer than a continuous two week period?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Sleep Apnea:**

A. What is your current treatment?

- CPAP/BIPAP  Dental Appliance  Surgery  Weight Loss  No Treatment

If **YES** to CPAP/BIPAP, have you used this for more than six months on a nightly basis?  Yes  No

If **YES** to Weight Loss or No Treatment, please select any other treatments that were recommended by your health care professional:

- CPAP/BIPAP  Dental Appliance  Surgery  None

B. Do you have any ongoing symptoms due to sleep apnea?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**KIDNEYS:**

Are you on dialysis?  Yes  No

If **NO**, what was the diagnosis? Check **ALL** that apply.

- Glomerulonephritis  Kidney Transplant  Nephrotic Syndrome  Pyelonephritis  
 Kidney Failure  Nephritis  Polycystic Kidney Disease  
 Other - Please answer the questions in **Section X - Other**.

**Pyelonephritis:**

Which of the following applies to your history of pyelonephritis:  Chronic  Acute  Unknown

Have you had more than one episode of acute pyelonephritis?  Yes  No

Do you have abnormal kidney function or continuous urine abnormalities?  Yes  No

Are you taking any medications for pyelonephritis?  Yes  No

If **YES**, please list medications. \_\_\_\_\_



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**LIVER:**

What was the diagnosis? Check **ALL** that apply.

Cirrhosis     Hepatitis A     Hepatitis B     Hepatitis C     Hepatitis - Type Unknown

[If Type A, has it been more than three months since you recovered from your Hepatitis A?]  Yes  No

Other - Please answer the questions in **Section X - Other**.

**GASTROINTESTINAL / DIGESTIVE SYSTEM:**

What was the diagnosis? Check **ALL** that apply.

Crohn's Disease     Pancreatitis     Ulcerative Colitis

Other - Please answer the questions in **Section X - Other**.

**Crohn's Disease:**

A. How old were you when the Crohn's Disease was diagnosed? \_\_\_\_\_

B. Has any surgery been recommended or has surgery been planned for the next 12 months?  Yes  No

C. Have you ever had any surgery for Crohn's Disease?  Yes  No

How many surgeries? \_\_\_\_\_

If **YES**, when was the last surgery? \_\_\_\_\_

D. Other than for surgery, have you been hospitalized for Crohn's Disease in the past [three] years?  Yes  No

E. Do you have any complications from Crohn's Disease (strictures, obstruction, abscess, fistulas, liver disease, anemia, other)?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

F. Have you had any weight loss due to Crohn's Disease in the past 12 months?  Yes  No

G. Please describe any symptoms of Crohn's Disease you have had in the past 12 months (fever, abdominal pain, diarrhea, other)? How often?

Symptom(s) \_\_\_\_\_ Frequency \_\_\_\_\_

H. Are you taking any medications for Crohn's Disease?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

I. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

J. Have you taken oral or intravenous steroids in the past 12 months?  Yes  No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_





**BLOOD:**

What was the diagnosis? Check **ALL** that apply.

- Anemia
- Leukemia
- Other - Please answer the questions in **Section X - Other**.

**Anemia:**

What type of anemia? Check **ALL** that apply.

- Iron Deficiency Anemia
- Sickle Cell Anemia
- Unknown
- Anemia Due to Blood Loss
- Thalassemia
- Other - Please provide details.

A. What is the source of blood loss? \_\_\_\_\_

B. Was heavy menses the source of blood loss? \_\_\_\_\_

- Yes
- No

If **NO**, please provide details. \_\_\_\_\_

C. How old were you when the anemia was diagnosed? \_\_\_\_\_

D. Have you ever been hospitalized due to anemia? \_\_\_\_\_

- Yes
- No

If **YES**, when were you hospitalized? \_\_\_\_\_

If **YES**, why were you hospitalized? \_\_\_\_\_

E. What treatment (including transfusions) have you received for anemia?  
\_\_\_\_\_

F. Are you currently receiving treatment for anemia? \_\_\_\_\_

- Yes
- No

If **YES**, please provide details. \_\_\_\_\_

G. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anemia? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

4. Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group? \_\_\_\_\_

- Yes
- No

If **YES**, please indicate which substance you were using:  Alcohol  Drugs  Both

**Alcohol/Both:**

A. Was this recommendation or counseling related to a DUI/DWI? \_\_\_\_\_

- Yes
- No

If **YES**, please answer the following questions.

1. Describe your current alcohol consumption:

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months, how often did you have more than four drinks in one day? \_\_\_\_\_

2. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? \_\_\_\_\_

How many drinks did you have on a typical day when you were drinking? \_\_\_\_\_

In a typical 12 month period, how often did you have more than four drinks in one day? \_\_\_\_\_



3. Are you currently in a support group?

Yes  No

If **NO**, when did you last drink alcohol? \_\_\_\_\_

Have you ever had a relapse (stopped using and then restarted using alcohol)?

Yes  No

Are you currently in a support group?

Yes  No

B. Have you ever had any medical complications due to drinking (liver disease, pancreatitis, other)?

Yes  No

Please provide the name and address (or any other contact information) of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

5. Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?

Yes  No

A. Please indicate the name of the drug or drugs used. Check **ALL** that apply.

Cocaine  Marijuana  Hallucinogens  Barbiturates

Heroin  Narcotics  Amphetamines

Other Illicit Drugs/Controlled Substances

Please provide details. \_\_\_\_\_

MARIJUANA ONLY:

Have you used Marijuana in the past 12 months?

Yes  No

If **YES**, how often do you use Marijuana per month? \_\_\_\_\_

Yes  No

B. Have you ever injected these drugs?

Yes  No

C. How old were you when you started using drugs? \_\_\_\_\_

D. When did you last use drugs? Date: \_\_\_\_\_

E. Have you ever sought counseling or medical attention because of your use of drugs (including hospitalization, in-patient and out-patient, rehabilitation)?

Yes  No

If **YES**, what was the date of your last treatment? Date: \_\_\_\_\_

F. Have you ever had a relapse (stopped using and then restarted using drugs)?

Yes  No

G. Do you drink alcohol?

Yes  No

If **YES**, answer the following questions describing your current alcohol consumption.

How often do you drink alcohol? \_\_\_\_\_

How many drinks do you have on a typical day when you are drinking? \_\_\_\_\_

In the past [three] months, how often did you have more than four drinks in one day? \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

6. Have you ever been diagnosed with or treated by a health care professional for Acquired Immune Deficiency Syndrome (AIDS)?

Yes  No



7. Have you ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus?  Yes  No
8. In the past [three] years, have you consulted a health care professional for a routine checkup or physical exam?  Yes  No
9. Other than previously disclosed, are you using any prescription medications?  Yes  No

If **YES**, please provide the names of all medications and the reason for each.

Names	Reason

10. Other than as indicated previously, in the past five years, have you been overnight in a hospital or other medical facility (excluding for childbirth, kidney stones, gallstones)?  Yes  No

If **YES**, please explain the reason for your stay and when this occurred.

Reason \_\_\_\_\_ When \_\_\_\_\_

11. Do you plan on scheduling surgery or any other medical procedure in the next [six] months that would require an overnight hospital stay (excluding for childbirth)?  Yes  No

If **YES**, what surgery or medical procedure and when is this scheduled?

Procedure \_\_\_\_\_ When \_\_\_\_\_

### SECTION VIII - Family History

Which of the following conditions has any parent or sibling been diagnosed with **prior to age [60]**? Check **ALL** that apply.

- Prostate Cancer     Ovarian Cancer     Lung Cancer     Congestive Heart Failure     Stroke  
 Breast Cancer     Colon Cancer     Melanoma     Aneurysms     Diabetes  
 Heart Attack/Coronary Artery Disease (Myocardial Infarction, Angina, Other)  
 None of the Above

Which of the following conditions has any parent or sibling been diagnosed with **at any age**? Check **ALL** that apply.

- Familial Colon Polyposis     Huntington's Chorea     Polycystic Kidney Disease  
 None of the Above

Please complete the following information for each family member diagnosed with any of the above conditions.

Relationship to Proposed Insured (You)	Age if Living	Age at Death	Specific Condition(s) (list all that apply)

If Familial Colon Polyposis:

- Have you had a colonoscopy in the past three years?  Yes  No  
 Were the results reported as normal?  Yes  No

### SECTION IX - Military

- A. Are you a member of the military services?  Yes  No
- B. Are you a dependent of a member of the military services?  Yes  No
- C. Do you serve in any of these special forces: Navy SEALs; Air Force Special Forces; Army Rangers; Delta Force; Army Special Forces?  Yes  No
- D. What is your current paygrade?  E1 thru E4     Higher than E4
- E. Are you being deployed abroad in the next 12 months?  Yes  No  
 Unknown

If **YES**, please provide details (when, where, what capacity)? \_\_\_\_\_



**SECTION X - Other**

A. What is the disease or disorder? \_\_\_\_\_

B. How old were you when you were diagnosed with the disease or disorder? \_\_\_\_\_

C. Do you currently have this disease or disorder?  Yes  No

If **NO**, when was the last time that you had symptoms related to this disease or disorder? \_\_\_\_\_

D. Have you had any surgery for this disease or disorder?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

What Surgery \_\_\_\_\_ When was the Surgery \_\_\_\_\_

E. Other than surgery, have you been hospitalized for this disease or disorder?  Yes  No

If **YES**: Why \_\_\_\_\_ When were you hospitalized \_\_\_\_\_

F. In the past [12] months what treatments have you received related to this disease or disorder?  
\_\_\_\_\_

G. What treatments are you currently receiving related to this disease or disorder?  
\_\_\_\_\_

H. Are you taking any medications for this disease or disorder?  Yes  No

If **YES**, please list medications. \_\_\_\_\_

I. Have you had any changes to your medications in the past 12 months?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

J. Has a health care professional recommended any future surgery or procedures related to this disease or disorder?  Yes  No

If **YES**, please provide details. \_\_\_\_\_

K. Except for scheduled health care appointments, have you missed any time from work or school in the past [12] months related to this disease or disorder?  Yes  No

How much time \_\_\_\_\_ Why \_\_\_\_\_

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

**Additional Information**

---

---

---

---

---

---

---

---

---

---



## Agreement / Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendments and supplements are the basis of any policy issued.
- This application and any amendments and supplements will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application including any amendments and supplements.
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No insurance will take effect until a policy is delivered to me and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) my condition of health is the same as stated in the application; and (b) I have not received any medical advice or treatment from a health care professional since the date of the application. If either (a) or (b) is not true, please contact the Company for re-evaluation of your application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I have requested a payment method of Electronic Funds Transfer from my bank account, I authorize the Company to initiate debit entries through Metropolitan Life Insurance Company to the deposit account identified in the application, using the Automatic Clearing House. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and my Financial Institution time to act on it.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**

## Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

## Signatures

Signature of Proposed Insured

Date

Signed at City, State



\_\_\_\_\_

