RF&G LIFE INSURANCE COMPANY LTD.

ADDITION OF DEPENDENTS HEALTH FORM

Name of Employer: _____ Group No.: _____

Name of Employee:_____

Names of Dependents	Relationship	Sex	Height	Weight	Date of Birth	Social Security No.

MEDICAL INFORMATION Please give details to any "Yes", answer below.

1. Has any dependent applying for coverage in the past 10 years had a diagnosis of or consultation, treatment or medication for.

	YES	NO		YES	NO
Brain or Nervous System	☐	☐	Thyroid or Pituitary Disorder	☐	☐
Nervous,Mental or Emotional Disorder	☐	☐	Diabetes or Sugar in Urine	☐	☐
Drug or Alcohol Abuse	☐	☐	Disease of the Muscle	☐	☐
Epilepsy or Cerebral Palsy	☐	☐	Bone or Joint Disorder	☐	☐
Abnormal Blood Pressure	☐	☐	Arthritis, Rheumatism, Bursitis	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Lungs or Respiratory System	☐	☐
Blood Disorder or Varicose Veins	☐	☐	Emphysema, Tuberculosis, Chronic Obstructive	☐	☐
Digestive or Gastrointestinal Tract	☐	☐	Pulmonary Disease or Asthma	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Liver, Pancreas or Kidney	☐	☐	Skin or Collagen Disease	☐	☐
Rectum, Prostate or Hernia	☐	☐	Cancer, Leukemia or Hodgkin's Disease	☐	☐
Genitourinary System	☐	☐	Lymphatic Vessels or Glands	☐	☐
Breast or Reproductive Organs	☐	☐	Any Physical Deformity or Defect	☐	☐
Endocrine or Adrenal Disorder	☐	☐			

2. Has any dependent applying been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats or enlarged glands? ☐ YES ☐ NO

3. Is any dependent being applied for currently pregnant, anticipating surgery or is anyone applying for coverage disabled, restricted or unable to perform the normal activities of daily living and self care? ☐ YES ☐ NO

4. During the past 5 years, has any dependent applying for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? ..... ☐ YES ☐ NO
5. Is any dependent currently taking medication?..... ☐ YES ☐ NO
6. Is there any existing medical condition or problem, including any undiagnosed symptoms that have not otherwise been indicated on this application? For "yes" answer provide details below. ..... ☐ YES ☐ NO

Use this space to give details to any "YES" answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages.
If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Person	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

I hereby apply for health insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions and I agree that the insurance provided covers the dependants listed above who are accepted. I have read the answers to the questions before signing this application and the answers are correctly written as given by me to the best of my knowledge; true and complete.

The Company shall not be liable under this application until it has been received and approved, and the full first as premium stipulated is paid to RF&G Life Insurance Company. This policy shall be deemed to have effect as of the policy approval date. Information given in your application maybe made available to other Legal Insurance, Third Party Administrator (TPA), Re-Insurers & medical institutions upon request.

I understand that no Agent is authorized to make change nullify in any way any applicable coverage section of the policy or to suppress any of the Company's requirement.

DECLARATION: I hereby declare that all proposed Insured dependents are domiciled in Belize for at least nine months and that my answers to medical questions asked in this application are answered truthfully and to the best of my knowledge. I also confirm that there are no known or ongoing illnesses that I am aware of.

_____	_____	_____
PLACE	DATE	SIGNATURE OF PROPOSED INSURED