Physical History Questionnaire

Policy # (if known): _____

Florida Version

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, New York 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name _____ MI _____ Last Name _____ Date of Birth _____ Social Security # _____

Check the condition(s) for which you have been treated by a member of the medical profession, and provide details in questions 2-12 below, as applicable:

1. ☐ Asthma ☐ Heart Disorder ☐ Nervous Disorder ☐ High Blood Pressure ☐ Sleep Apnea
   ☐ Diabetes ☐ Liver Disorder ☐ G. I. Tract Disorder ☐ Reproductive Disorder ☐ Other_____
   ☐ Tumor ☐ Back Disorder ☐ Urinary Disorder ☐ Respiratory Disorder

   Describe symptoms: _____ Date of onset: _____
   (If ulcer, any bleeding?) _____
   What special tests were done? _____ Results? _____
   What diagnosis was made? _____ Any malignancy?_____
   When?_____ Duration of illness? _____

2. What type treatment did you receive by a member of the medical profession:

A. Surgery?	☐ Yes ☐ No	What type?
B. Radiation Therapy?	☐ Yes ☐ No	What type?
C. Medication?	☐ Yes ☐ No	What medication? Dosage?
D. Other?	☐ Yes ☐ No	Describe: If insulin, how many units? If diabetic, furnish date and results of last blood sugar test:

3. Are you currently under treatment by a member of the medical profession?
   ☐ Yes ☐ No (If yes, give type and reason) _____
   (If no, when was treatment discontinued?)_____
4. Has additional treatment or surgery been suggested by a member of the medical profession? _____
5. Have you been confined to the hospital? ☐ Yes ☐ No When? _____ How long? _____
6. When did you last consult a doctor? _____ Reason? _____
7. Have there been any recurrences? ☐ Yes ☐ No How many? _____
   Frequency? (Number of attacks in past 12 months) _____
8. Has this problem caused you to be disabled for more than one month? ☐ Yes ☐ No How long?_____
9. Amount of time missed from work/social activities in the past year related to this problem? _____
10. Any associated diseases or complications? ☐ Yes ☐ No Explain _____
11. Furnish blood pressure readings: Highest _____/ _____ When? _____
    Lowest ___/ _____ When? _____Usual _____/ _____ Latest _____/ _____ When?_____
    Furnish names and addresses of all doctors and hospitals referenced above and indicate by "X" who has complete records.
    _____
    _____
12. Additional comments_____

Agreement: I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they and this questionnaire shall form a part of my application for insurance. I agree that my failure to disclose any material fact known to me may invalidate the contract.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Proposed Insured Signature

X

Signed at (city, state) _____

Signed on (date) _____