



- 11. Blindness.....  Yes  No
- 12. Optic Neuritis.....  Yes  No
- 13. Osteoporosis with fractures .....  Yes  No
- 14. Parkinson's disease .....  Yes  No
- 15. Post-Polio Paralytic Syndrome.....  Yes  No
- 16. Polymyositis.....  Yes  No
- 17. Scleroderma .....  Yes  No
- 18. Memory loss .....  Yes  No
- 19. Unplanned weight loss greater than 15 pounds within the last 2 years.....  Yes  No
- 20. Arthritis with narcotic pain medication within the past 12 months.....  Yes  No
- D. Do you have a parent or sibling diagnosed or treated by a licensed health care provider for Huntington's chorea or Polycystic Kidney Disease? .....  Yes  No

**If any question in 3. A-D was answered yes, the rider is not available for the Primary Proposed Insured and this supplemental application should not be completed or submitted.**

- E. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:
  - 1. Disorientation .....  Yes  No
  - 2. Multiple falls or injury due to a fall .....  Yes  No
  - 3. Chest Pain .....  Yes  No
  - 4. Loss of balance .....  Yes  No
  - 5. Loss of strength.....  Yes  No
  - 6. Tremors .....  Yes  No
  - 7. Dizziness.....  Yes  No
- F. Do you have a handicap sticker, handicap placard, or handicap license plate? (If yes, give reason below) .....  Yes  No
- G. In the last 24 months, have you been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below) .....  Yes  No
- H. In the past 24 months, have you required assistance with shopping, arranging transportation, housekeeping, cooking, laundry, meal preparation, managing finances, managing medications, using the telephone or used a straight cane? (If yes, give reason below) .....  Yes  No

**Give details to all yes answers to questions 3. E-H.**

Question #	Nature of Condition/Date of diagnosis	Date of last treatment or last medication taken	Name & address of Physician seen

- I. Within the past 5 years, have you received any long term care benefits, disability income benefits or Social Security Disability Income Benefits? (If yes, please provide details in **Section 4, Remarks.**) .....  Yes  No
- J. Within the past 5 years, have you been declined for long term care insurance, including long term care or chronic illness insurance provided by rider to a life insurance or other policy including annuities? (If yes, please provide the name of the company, date and the reason in **Section 4, Remarks.**) .....  Yes  No

**4. Remarks**

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I, the Primary Proposed Insured signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within the contestable period.

I understand that benefits under the Chronic Illness and Terminal Illness riders are provided through an accelerated death benefit option, and that if I exercise the accelerated benefit option, any beneficiary I designate will receive a reduced death benefit.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Primary Proposed Insured Signature**

X
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**Date** \_\_\_\_\_

**Licensed Writing Agent**

X \_\_\_\_\_

**Date** \_\_\_\_\_

**Writing Agent Name** \_\_\_\_\_

**Writing Agent Number** \_\_\_\_\_

**Agency Number** \_\_\_\_\_

