

**EVIDENCE OF INSURABILITY**

**MUTUAL MEDICAL PLANS, INC.**

Employee's Last Name	First	Middle Initial	Occupation	Birth Date	Place of Birth-State	Height	Weight
Group Number	Certificate No.	Date Employed	Group Name				

THIS APPLICATION IS FOR:  EMPLOYEE ONLY  DEPENDENTS ONLY  EMPLOYEE AND DEPENDENTS

NOTE: If applying for dependent coverage, list all eligible dependents. If spouse not included please explain.

Name of Dependent	Relationship	Date of Birth	Ht.	Wt.	Name of Dependent	Relationship	Date of Birth	Ht.	Wt.
	SPOUSE								

- 1 Within the next three months, do you or a dependent plan - or has someone recommended for you or a dependent - any medical treatment, consultation, observation, test, lab work or study of any kind? If yes, give details under No. 6. NO  YES
- 2 Have you or any dependent ever had, ever been told you had, or ever been treated for cancer, diabetes, epilepsy, nervous or mental disorder, digestive disorder, glandular disorder, high blood pressure, heart disease, back or spine disorder, respiratory disorder, artery or vein disorder, genito-urinary disorder, alcoholism or drug usage? If yes, circle impairment(s) and give details under No. 6. NO  YES
- 3 Within the past five years, have you or any dependent been confined to a hospital or similar institution, undergone any surgical or medical treatment, therapy, studies, or observation; consulted anyone; or been examined or treated by anyone? If yes, give details under No. 6. NO  YES
- 4 Have you or any dependent ever been declined, postponed, limited or rated for any insurance? If yes, give details under No. 6. NO  YES
- 5 To the best of your knowledge are you or any dependent pregnant, or have any illness, impairment, or disease? If yes, give details under No. 6. NO  YES

**6 MEDICAL HISTORY STATEMENT** (If you answered any question "YES," please complete medical history statement below.)

Question No.	Employee or Dependent Name	Nature of Illness, Surgery, Treatment or Injury	When? (Date)	How Long?	Fully Recovered? State Yes or No	Name & Address of Physician and/or Hospital

7 Has Employee Or Dependent Ever Participated In Aviation, Racing, Parachuting, Diving, Or Any Other Hazardous Activity?  
 NO  YES If Yes, please explain.

**AUTHORIZATION**

I authorize the release of any information needed to process the above information.

**NOTE: ANY OMISSION OR MIS-STATEMENT ON THIS FORM MAY CAUSE COVERAGE TO BE RESCINDED.**

<b>8</b>		<b>X</b>
DATE	PLACE SIGNED (CITY, STATE)	SIGNATURE OF EMPLOYEE/APPLICANT