Statement of Physical Condition

Congregation ______________________________

Conference ______________________________

Name of employee ______________________________ Birth date ______________

Daytime phone number (_______) ______________ Gender ☐ male ☐ female

Height __________ Weight __________ Hours worked per week __________

Names of Dependents To Be Insured	Gender	Birth Date	Height	Weight
	☐ male ☐ female			
	☐ male ☐ female			
	☐ male ☐ female			
	☐ male ☐ female			

Please complete information for all applicants to be considered.

Answer the following questions and give details for every "yes" answer. Circle the specific problem. Use another sheet of paper if necessary. Incomplete details will result in this application being returned for more information.

	Yes	No
1. Have you or any of your dependents		
a. ever been medically treated or diagnosed for a heart condition, circulatory disorder, diabetes, cancer, or tumor?..	☐	☐
b. been medically treated or diagnosed in the past five years for high blood pressure; nervous respiratory, digestive, urinary, or skeletal disorder?..	☐	☐
c. ever received professional advice or treatment or been arrested for the use of alcohol or drugs? .	☐	☐
d. consulted or been attended by a doctor, psychiatrist, psychologist, or practitioner within the past five years for other than routine exams?..	☐	☐
e. been diagnosed as HIV positive or as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other immune disorder?..	☐	☐
2. Are you or any of your dependents presently receiving any treatment or taking any medication?... Please list all medications along with the individual taking that medication below.	☐	☐
3. Do you or any of your dependents have any known physical or mental impairments, deformities, or ill health not covered above?..	☐	☐

Please provide the following details for any question to which you answered "yes."

For recurring visits for a chronic condition, list as one visit, with the most recent visit only. For a major one-time health event – such as treatment for a broken limb – list the date of initial treatment and most recent visit only.

Question Number	Person To Be Insured	Physician's Name and Address	Date Consulted	Diagnosis	Treatment and Medications	Complete Recovery?

	Yes	No
4. Are you or any of your dependents pregnant? If **yes**, give person and due date. ______	☐	☐
5. Have you or any of your dependents been denied life or health insurance for any reason? If **yes**, give person, date, and reason. ______	☐	☐
6. Have you or any of your dependents used tobacco in the past 12 months? If **yes**, give person, type of tobacco, and how much used. ______	☐	☐

By this form (or a photocopy of it), I authorize any licensed physician; medical practitioner; clinic; hospital or other medically related facility; insurance company; the Medical Information Bureau; or other person, organization, or institution that has any records or knowledge of me or my dependents for whom insurance application is made for my health or their health, to give to MMA Insurance Company, or its reinsurers any such information and to testify as to such information, all to the extent permitted by law. This authorization is valid from the date signed for 12 months. A photocopy of this authorization shall be as valid as the original.

I understand this information will be used for group underwriting purposes only and will not be disclosed to my employer.

____
Signature of employee — Date

____
If spouse applying, signature required — Date

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