J.P. FARLEY CORPORATION
WE HAVE A BETTER PLAN.

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HEALTH STATEMENT QUESTIONNAIRE

This information is strictly confidential and will only be released to prospective medical insurance providers. Your assistance in providing complete and accurate information will enable us to respond quickly and without requesting additional information whenever possible. If additional space is necessary, please attach a separate sheet.

Employee Information

EMPLOYEE NAME			EMPLOYER	
HOME ADDRESS		**CITY, STATE, ZIP**	**HOME PHONE** ( ) -	**WORK PHONE** ( ) -
DATE OF BIRTH	**SEX**	**TYPE OF COVERAGE (CHECK ONE)** ❑ SINGLE ❑ EMPLOYEE/SPOUSE ❑ EMPLOYEE/CHILD(REN) ❑ FAMILY		

Dependent Information

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH

Please answer the following questions for you and any dependents to be covered under this plan.
If you answer "Yes" to any questions, please provide explanation in the next section of this form.

Question	Yes	No
1. Has anyone been treated for serious illness or had major surgery in the past 12 months?	❑ Yes	❑ No
2. Does anyone have an existing mental or physical disorder?	❑ Yes	❑ No
3. Has anyone been advised to have surgery in the six months or anticipate hospitalization, special studies or tests?	❑ Yes	❑ No
4. Is anyone currently taking prescribed medication(s)?	❑ Yes	❑ No
5. To your knowledge, is any person to be covered now pregnant?	❑ Yes	❑ No
6. Has anyone missed 10 or more consecutive days from work/school in the past 12 months due to illness or injury?	❑ Yes	❑ No
7. Are there any family members who are confined at home, incapacitated or confined in a hospital or treatment facility?	❑ Yes	❑ No

Have you or any of your dependents consulted a doctor, been hospitalized for, or had any indication of symptoms of:

Condition	Yes	No
a. Heart attack, chest pain, elevated blood pressure, heart murmur, irregular pulse, rheumatic fever, abnormal electrocardiogram, thrombosis, stroke, impaired circulation or anemia?	❑ Yes	❑ No
b. Asthma, emphysema, hay fever, allergies, chronic bronchitis or other disease or disorder of the lungs or respiratory system?	❑ Yes	❑ No
c. Ulcers, colitis, hemorrhaging or other impairments of the stomach, intestines or esophagus?	❑ Yes	❑ No
d. Infections or disorder of the kidneys, urinary bladder or genital organs?	❑ Yes	❑ No
e. Hepatitis, cirrhosis or any disease or disorder of the liver or gall bladder?	❑ Yes	❑ No
f. Mental or nervous disorder, seizure disorder (including epilepsy), fainting or dizzy spells?	❑ Yes	❑ No
g. Tumors, cancer, leukemia or Hodgkin's Disease?	❑ Yes	❑ No
h. Diabetes (or elevated sugar in the blood) or any disorder of the thyroid gland?	❑ Yes	❑ No
i. Back, spine, bone, muscle or joint disease or disorder (including arthritis)?	❑ Yes	❑ No
j. Alcohol or drug abuse or addiction?	❑ Yes	❑ No
k. Eye or ear disease or disorder (including complete or partial blindness and/or deafness)?	❑ Yes	❑ No
l. Disorder of menstruation or pregnancy?	❑ Yes	❑ No
m. AIDS, ARC or any immune system disorder?	❑ Yes	❑ No

If you answered "Yes" to any of the previous questions, please provide additional information for each claimant. If additional space is needed, please use a separate sheet.	
CLAIMANT'S NAME	**DIAGNOSIS**
DATE OF DIAGNOSIS	**DOCTOR'S NAME/ADDRESS**
DATE DOCTOR LAST CONSULTED	**CURRENT/ANTICIPATED TREATMENT**
DATE OF SURGERY/TYPE OF SURGERY	**DATE OF HOSPITALIZATION/LENGTH OF STAY**
HOW LONG OUT OF WORK/SCHOOL?	**NAMES/DOSAGES OF MEDICATION**

Please provide this additional information for the following conditions:

1. **PREGNANCY**
   Due Date
   Any complications with previous births
   Previous Ceasarian sections (If yes, how many?)
2. **DIABETES**
   Age When diagnosed
   Current height and weight
   Last sugar reading/date
   Any complications to date
3. **HIGH/ELEVATED BLOOD PRESSURE**
   Date first diagnosed
   Blood pressure reading and date when last checked
   Any complications to date
4. **EPILEPSY**
   Number of seizures in the past 12 months
   Type of diagnosis (grand mal, petit mal, or other)
5. **ASTHMA/EMPHYSEMA**
   Number of days spent completely disabled in the past month
6. **HAY FEVER/ALLERGIES**
   Date of onset
   Nature of treatment
   Date last treated
7. **DRUG/ALCOHOL ABUSE**
   Name of drug(s)
   Average weekly amount of drugs/alcohol used
   Give dates of any confinement in a hospital/institution
   Current treatment program, if any

Acknowledgement

I hereby attest that the information provided on this "Medical Risk Questionnaire" is true and factual to the best of my knowledge. I understand that any willful misrepresentation of fact on this form is considered fraud and will carry penalties associated with such fraud. I authorize the release of the above information to prospective medical insurance providers.

Employee Signature____ Date ______________

Print Employee Name____