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.

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

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**

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_____