STATE INSURANCE
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FORM II

STATEMENT OF HEALTH - NON-MEDICAL
DECLARATION OF APPLICANT IN LIEU OF MEDICAL EXAMINATION

N.B. -Every question in this form must be fully answered by applicant in the presence of the representative.

1. Name in full — Date of Birth

2. Nationality — Sex

3. Single, married, divorced, etc. — How many children born? — How many living?

4. Family History	IF LIVING		IF DEAD		THIS SPACE FOR DETAILS
	Age	State of Health	Age at Death	Cause of Death	
Father					
Mother					
Brothers					
Sisters					
Spouse					

5. Have any of the above relatives ever suffered from mental illness, epilepsy, diabetes, tuberculosis or heart disease? If so, please give details ..... Yes No

6. Are you now living with, or have ever lived or been associated with, any person or persons suffering from tuberculosis, consumption or weak lungs? If so, give relationship and state when ..... Yes No

7. Have you ever changed or been advised to change your occupation or residence for the benefit of the health? If so, state when and why ..... Yes No

8. Have you ever applied for or received compensation because of ill health or injury? If so, give complete details ..... Yes No

When any question hereunder is answered in the affirmative, give complete details with date, duration, severity, result and the name and address of each practitioner consulted.

9. Have you ever had or consulted a practitioner for:

a. Rheumatism, (Rheumatic Fever), Arthritis, Gout, Goiter (or Thick Neck), Diabetes, Malaria, Cancer, Tumor, Syphilis or other Venereal Disease, Tuberculosis of Lungs or any other part of the body? ..... Yes No

b. Severe Headaches, Fits, Epilepsy, Dizziness, Paralysis, Sleeping Sickness, Debility, Nervous Breakdown, Mental Derangement? ..... Yes No

c. Fainting Spells, Fatigue, Shortness of Breath, Pain in Chest, Abnormal Blood Pressure, Palpitation or any affection of the Heart?..... Yes No

d. Asthma, Bronchitis, Pneumonia (Inflammation of Lungs), Persistent Cough, Raising of Blood or any affection of Chest or Throat? ..... Yes No

e. Ulcer of Stomach or Bowels, Indigestion, Disease of Gallbladder, Appendicitis, Colic (kind), Fistula, Piles, Dysentery, Colitis?..... Yes No

f. Sugar or Albumen in the urine, painful, difficult or frequent urination, Gravel, Stone or any disease of Kidneys or Bladder?..... Yes No

g. Discharge from Ear? Impairment of Hearing or Vision? …..... Yes No	THIS SPACE FOR DETAILS
h. Any Deformity, Spinal Curvature, Hip Disease, Lameness, Loss of Limb, Rupture or other disabling condition? ……..... Yes No	
10. Have you ever been examined or treated by X-rays?…….…..…..….. Yes No	
11. Have you ever had an electrocardiogram made? …….…..…..…..... Yes No	
12. Have you ever been under observation, care or treatment in a hospital, sanatorium or other institution not mentioned above?..... Yes No	
13. Have you had any illness, disease, injury, operation or examination of which full details have not been given above?..... Yes No	
14. Give name and address of your regular physician and of each physician who has examined you or attended you within the past 5 years	
15. What is the present and general state of your health?.....	
16. a. To what extent do you use alcoholic stimulants?.....	
b. Have you ever used them to excess? ..... Yes No	
c. If you are a total abstainer, how long have you been one?	
17. a. What is the daily amount of cigarettes, cigars or tobacco do you smoke?	
b. If you do not currently smoke for how long have you refrained?	
18. a. Have you ever had any blood serum test for immune systems deficiency? .... Yes No	
b. Have you experimented with drugs which are not legally available or prescribed? If yes, give full details ..... Yes No	
c. Are you aware of any specific risk of acquiring any immunity deficiency? If yes, please give full details ..... Yes No	

19. a. What is your height (without shoes)? ……..... b. What is your weight (in indoor clothes) ……..…….....

c. Have you gained or lost weight during the last 2 years?..... ..... If so, please give details, explaining cause and amount

……..…….....

20. Female Applicants:

a. Are you pregnant? ……..…….....

b. Have you consulted a physician for any disease peculiar to your sex? …….. If so, give details .....

……..…….....

The forgoing answers are full, complete and true; are material to, are a continuation of, and form part of the Application for Assurance on my life.

Dated at ……..…….....….. this ……..…….....…… day of ……..…….....…….. 20……

Witness ……..…….....…….…… Representatives. ……..…….....……...

Signature of person whose life is to be assured.