WICHITA NATIONAL LIFE

INSURANCE COMPANY

HEALTH STATEMENT

RE: Certificate # _____

We recently received an application for credit insurance covering a loan you made through the following institution.

_____

In order to accept/retain the risk of this credit insurance, we need the following health statement completed and returned to our office in the enclosed postage paid envelope.

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY: (Use back side for more space.)			
1. Do you have or have you ever been treated for:	YES	NO	For all "YES" answers, indicate name and address of doctor(s), date and type of treatment and current condition.
a. Lung or respiratory disorder?			
b. Ulcers or stomach disorder?			
c. Disorders of the nervous system?			
d. Diabetes? (Specify type of medication)			
e. Cancer? (Specify type, present condition & date of last treatment)			
f. High blood pressure? (Last three readings)			
g. Stroke?			
h. Kidney disease? (Specify type of medication)			
i. Liver disease? (Specify type of medication)			
j . Heart or Cardiovascular disease? (Specify type of medication)			
k. Medical or chiropractic treatment for your back, neck, spine, shoulder or knee? Carpal Tunnel Syndrome?			
l. Drug or alcohol abuse?			
m. Mental or emotional disorder?			
n. An immune deficiency disorder, AIDS, the AIDS related complex (ARC) or tests resulting in the indication of the AIDS virus?			
2. Are you now taking medication other than listed above? Specify type.			
3. Have you been confined in the last 5 years to a hospital or sanitarium or seen a doctor for any reason other than listed above? If yes, please give full details on the back of this form.			
4. Are you self-employed?			
5. Are you working less than 30 hours per week for wages or profit?			
6. Within the past twelve (12) months have you been disabled (unable to work) or received any disability benefits?			
7. Are you in good health?			

Your occupation _____ **SSN#** _____

Height _____ **Weight** _____ **Date of Birth** _____ **Age** _____

I hereby certify that the answers to the above questions are correct to the best of my knowledge and belief. I understand they will be the basis of any insurance granted or retained. For this reason, I further understand there is no obligation on the Company's part to make any investigation or underwriting decisions until a claim has been filed and if the aforesaid representations are false and untrue the Company's liability shall be limited to the return of the premium paid for said coverage.

WARNING: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

Date _____ _____

Signature of Applicant (Full Legal Name)

FAILURE TO COMPLETE THIS FORM COULD RESULT IN TERMINATION OF YOUR INSURANCE.
PLEASE RETURN WITHIN ONE WEEK.

REVISED 07/07

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