Company Name: ______________________

Employee Name: ______________________

STERLING

RISK ADVISORS

Complete this section for employees and dependents enrolling or potentially enrolling for medical, disability and/or life insurance coverage. All medical questions should be answered in relation to treatment or diagnosis made by a medical professional or physician. ALL QUESTIONS, UNLESS OTHERWISE INDICATED, ARE LIMITED TO THE LAST 5 YEARS.

☐ I am choosing to waive coverage at this time and do not need to answer the following questions.

1) Are you or any dependent currently under any treatment or prescribed medication? ☐ No ☐ Yes

2) Have you or any dependent had unexplained weight loss or fatigue in the past 12 months? ☐ No ☐ Yes

3) Have you or any dependent had, been diagnosed with, counseled, consulted or treated for any of the following in the past 5 years:
   - a) Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure? ☐ No ☐ Yes
   - b) Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness? ☐ No ☐ Yes
   - c) Asthma or other disease of lung or respiratory organs? ☐ No ☐ Yes
   - d) Kidney stones; disease of kidney, bladder, male or female organs; or infertility? ☐ No ☐ Yes
   - e) Cancer, and/or cancerous tumor? (state type; part of body) ☐ No ☐ Yes
   - f) Diabetes; liver or thyroid disease; or enlargement of the lymph nodes? ☐ No ☐ Yes
   - g) Stomach, gall bladder, intestinal or colon disorders? ☐ No ☐ Yes
   - h) Rheumatoid arthritis or back disorders? ☐ No ☐ Yes
   - i) Phlebitis, paralysis, or any other physical impairment or deformity? ☐ No ☐ Yes
   - j) Alcoholism or drug habit, or been a member of Alcoholics Anonymous? ☐ No ☐ Yes

4) Have you or any dependent been diagnosed or received treatment for AIDS related complex within the past 5 years? ☐ No ☐ Yes

5) Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned? ☐ No ☐ Yes

6) Are you or any dependent pregnant or had a cesarean section? ☐ No ☐ Yes

7) Please provide height/weight information for all applicants enrolling for coverage:

Employee Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

Spouse Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

Dependent Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

Dependent Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

Dependent Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

Dependent Date of Birth: __________ Height (ft' in") __________ Weight (lbs) __________

If you answered "Yes" to any of the questions above, please provide details below and specify the question. Attached additional signed and dated sheets as needed.

Question Number: ________ Person Treated Last Name: __________ First Name: __________

Condition: ______________________

List symptoms encountered: ______________________

List treatment received: ______________________

List medical test administered: ______________________

Medication(s) taken: ______________________

Date condition was first diagnosed: __________ Date last seen by a doctor for this condition: __________

Please note that this information will remain confidential and will only be used by Sterling Risk Advisors to find the best medical coverage for you and your employer.