As described below, I hereby voluntarily authorize Tiedtke Marketing Group (TMGI) to disclose my individually identifiable health information and that of my covered dependents. I understand that the information will only be disclosed for the purpose of obtaining insurance benefits and may be revoked at any time by notifying TMGI in writing.

SECTION A: HEALTH STATEMENT FOR EMPLOYEE AND DEPENDENTS -You must answer all questions for yourself and all dependents requesting coverage. Date and initial any changes or corrections. Please provide details to all "Yes" answers below. For confidentiality, you may enclose your form in a sealed envelope.

1. Has any applicant in the last 10 years had, been medically advised of having, been treated for or been referred for treatment (including medications), advice or hospitalization for any of the following? CHECK APPROPRIATE BOX AND CIRCLE ALL THAT APPLY. PROVIDE DETAILS TO "YES" ANSWERS BELOW.

A. Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles or joints, or arthritis?........ ☐YES ☐NO

B. Any disorder/disease of the digestive system, urinary tract, kidneys, reproductive system/infertility?.............. ☐YES ☐NO

C. Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, or birth defect?............................ ☐YES ☐NO

D. Any mental, nervous, or behavioral disorder, chemical imbalance, alcoholism or drug abuse or addiction?..... ☐YES ☐NO

E. Diabetes? If YES, last blood sugar reading and date: ____ ☐YES ☐NO

F. High blood pressure? If YES, last 3 blood pressure readings and dates:____________________________ ____ ☐YES ☐NO

2. HAS ANY APPLICANT IN THE LAST 10 YEARS HAD, BEEN DIAGNOSED WITH, BEEN TREATED FOR OR REFERRED FOR TREATMENT(S) (INCLUDING MEDICATIONS) OR HOSPITALIZATION FOR AIDS, ARC, OR ANY IMMUNE SYSTEM DISORDER?.. ☐YES ☐NO

3. IN THE PAST THREE YEARS HAS ANY APPLICANT HAD MEDICAL EXPENSES OR CLAIMS OF $5,000 OR MORE?... ☐YES ☐NO

4. IS THE EMPLOYEE OR DEPENDENT PREGNANT (WHETHER APPLYING FOR COVERAGE OR NOT)?... ☐YES ☐NO
IF YES, NAME:____ ANTICIPATED DUE DATE: ______________________
ANY HISTORY OF COMPLICATIONS, PREMATURE BIRTH, OR C-SECTION?.. ☐YES ☐NO

Please provide details for all "YES" answers to the health questions above. Print legibly and complete all columns. Attach additional paper if necessary and be sure to sign and date it.

NAME OF PERSON TREATED	CONDITION/DIAGNOSIS	DURATION: FROM (MTH/YR) TO (MTH/YR)	EXPLAIN TREATMENT, HOSPITALIZATION, TESTS AND SURGERY	MEDICATIONS	DATE LAST TREATED	FINAL RESULTS / DEGREE OF RECOVERY

NAME ________________________
SEX ________________________
DATE OF BIRTH ________________________
HEIGHT ________________________
WEIGHT ________________________
SIGNATURE ________________________

DO YOU USE TOBACCO?
☐YES
☐NO

PLEASE NOTE: This same information is needed on each family member who is to be insured. Use a separate sheet of paper if necessary.