

Application to:

ALTA HEALTH & LIFE INSURANCE COMPANY
PISCATAWAY, NJ 08855

Your Employer's Group Policy No. **G-661**

SECTION A (Questions 1 - 12 refer to the life of the Proposed Insured)

<p>1. Full Name (Print) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female (First) (Middle) (Last) (Maiden)</p>	<p>8. Are you presently in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," give full details in No. 11.</p>						
<p>2. Date and Place of Birth: Month Day Year State</p>	<p>9. Have you smoked one or more cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>3. Age Last Birthday SS # - -</p>	<p>10. Have you engaged in aviation activities other than as a passenger on a commercial airline in the last two years, or do you contemplate doing so? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						
<p>4. Home Address: (No., Street, City, County, State and Zip Code) Phone:</p>	<p>11. Details of answers to Questions 6, 7, and 8.</p>						
<p>5. Occupation: (Describe duties; state employer's name & address)</p>	<p>12. Amount of Optional Group Life Insurance for which application is made \$ _____</p>						
<p>6. Are you presently actively at work in your usual occupation on a full time basis (30 or more hours a week)? If "No," give full details in No. 11. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Beneficiary, to whom death benefits are to be payable</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name</th> <th style="text-align: left;">Relationship to proposed insured</th> <th style="text-align: left;">Date of Birth</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Name	Relationship to proposed insured	Date of Birth			
Name	Relationship to proposed insured	Date of Birth					
<p>7. Have you ever had any application or reinstatement for life insurance, disability or health insurance declined, rated or modified in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give full details in No. 11.</p>							

SECTION B (All Questions refer to the life of the Proposed Insured)

<p>14. Height (in shoes) ___ft. ___in. Weight ___lbs.</p>	<p>d) Cancer, tumor, or diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
<p>15. Have you ever had or been told you have, or ever been treated for:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>a) Elevated blood pressure?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b) Disorder of the heart or circulatory system?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c) Chest pains or heart murmur?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	a) Elevated blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	b) Disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	c) Chest pains or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<p>e) Mental illness or disease of the nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) Albumin, blood or sugar in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	Yes	No											
a) Elevated blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>											
b) Disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>											
c) Chest pains or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>											
<p>16. Name of personal physician; date and reason for last visit</p>													
<p>17. Have you been under observation or treatment by any Physician, within the last five years for any reason not already covered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>													
<p>18. Give "details" to any "Yes" answers to questions in Section B.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Question</th> <th style="text-align: left;">Condition</th> <th style="text-align: left;">Treatment & Results</th> <th style="text-align: left;">Name & Address of Physician or Hospital</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Question	Condition	Treatment & Results	Name & Address of Physician or Hospital									
Question	Condition	Treatment & Results	Name & Address of Physician or Hospital										

(If space is inadequate attach Signed & Dated supplement)

AGREEMENT

I hereby agree as follows:

1. The application consists of a) This page, b) any amendments thereto; and c) any supplements required by the company published initial application rules.
2. I have read the statements in the application and they a) are true and complete to the best of any knowledge and belief, and b) were correctly recorded before I signed the application.
3. **INSURANCE TAKES EFFECT** on the date the Application is approved by Alta Health & Life Insurance Company (Alta) provided the first full premium, as billed, is paid within 31 days of Notice.
4. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give to Alta, any such information. A photographic copy of this authorization shall be as valid as the original. I also acknowledge receipt of the "Notice to applicant."

Dated at _____ on _____ 20____ Signature of Applicant _____
City State