ALTA HEALTH & LIFE INSURANCE COMPANY

1 Centennial Avenue
P.O. Box 1326
Piscataway, NJ 08855-1326

PLEASE PRINT. PRESS FIRMLY WITH BALL POINT PEN.

STATEMENT OF HEALTH TO INSURE MY CHILDREN

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME	SEX ☐ M ☐ F	EMPLOYEE'S DATE OF BIRTH
RESIDENCE ADDRESS		NASA CENTER AT WHICH EMPLOYED

EMPLOYEE'S MARITAL STATUS: ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

1. List all unmarried children under 19 years of age (Print full name)	Relationship	Date of Birth		
		Mo.	Day	Year

If answer to any of the following is "Yes," give details in "4" below.

2. Has any child had or been treated for any of the following:

	Yes	No
a) Heart murmur, rheumatic fever, or other disorder of the heart?	☐	☐
b) Tuberculosis or recurrent asthma in the past five years?	☐	☐
c) Ulcer symptoms or liver disease in the past five years?	☐	☐
d) Any kidney trouble or diabetes?	☐	☐
e) Albumen, sugar, or blood in the urine?	☐	☐
f) Any tumor, cancer, anemia, or blood disorder?	☐	☐
g) Any mental or nervous disorder or convulsions?	☐	☐
h) Any birth defects?	☐	☐

3. Has any child

	Yes	No
a) Attended a special school (because of physical handicap or other reasons)?	☐	☐
b) Had an electrocardiogram or brain wave test?	☐	☐
c) Been hospitalized or admitted to other institutions for diagnosis or treatment for any condition not already mentioned?	☐	☐

4. Please give details of all "Yes" answers to above questions: *(If space is inadequate, attach signed and dated statement.)*

CHILD'S NAME	CONDITION	DATE	TREATMENT & RESULTS	NAME OF PHYSICIAN SPECIAL SCHOOL OR HOSPITAL	ADDRESS

I acknowledge that the above statements and answers are true and complete to the best of my knowledge and shall be used as a basis for underwriting any coverage that may be granted. I also acknowledge that the Insurance Company has furnished me a copy of this instrument containing my answers, statements and explanations.

Signed at _____ (PLACE) on _____ (DATE) 19_____

_____ (SIGNATURE)

1 COPY RETAINED BY THE APPLICANT, 2 COPIES MUST BE SUBMITTED TO NEBA INSURANCE OFFICE

FOR OFFICE USE ONLY

On the basis of the above evidence, you request to obtain for your children dependents group life insurance – in accordance with the Dependents Life Insurance Rider attached to Group Policy No. GL-661 and subject to all the terms and conditions of that Policy and that Rider – is hereby

☐ granted with respect to your children named herein and all of your subsequent children, except for:

_____

☐ declined

Date_____ By_____

Dept. No. G-624 (NASA)-1 8-80 **CHILD FORM** **ALTA HEALTH & LIFE INSURANCE COMPANY**

GPO-119-624G (2/00)

AUTHORIZATION

Please give to Alta Health & Life Insurance Company all information it may request regarding medical history and physical condition of _____ (INSERT NAME OF PERSON TO BE EXAMINED)

A photostatic copy of this authorization shall be considered as valid as the original. Thank you for your courtesy.

_____ SIGNATURE OF THE EMPLOYEE WHO COMPLETED THE ABOVE STATEMENTS

_____ ADDRESS