



Return to:

Simple IR The Employee Management Solution

BCS LIFE INSURANCE COMPANY Chicago, Illinois

1077 East Highway 98, Suite 200 Destin, FL 32541

\$ Insurance Amount

GROUP INSURANCE HEALTH STATEMENT - SHORT FORM

EMPLOYEE

Name of Employee, Social Security Number, Employee's Residence Address, Telephone Number(s), Date of Birth, Place of Birth

Name of Group Employer/Policyholder, Group Policy No., Occupation (Describe), Date Employed

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED

1. Height, 2. Weight, 3. Do you have any physical or mental impairments..., 4. Have you ever been treated for..., 5. Have you had any illness, injury, operation or condition..., 6. Have you missed work..., 7. Have you ever been declined or rated..., 8. If you answered YES..., 9. Attach a separate sheet...

I apply for insurance and understand that if I am disabled or not able to perform the duties of a person of the same sex or age or am confined at home or in a hospital at the time of this application...

I understand that the insurance applied for shall become effective on the date specified by BCS Life Insurance Company...

I authorize any physician, medical practitioner, hospital, clinic Medical Information Bureau or medically related facility, insurance company, or employer that has any health related records or knowledge of me or my dependents to give to the Company...

I acknowledge that I have read, or had read to me, this completed application and that I realize that any false statement or misrepresentation in application may result in loss of coverage under the policy.

Date Signed

Employee's Signature