

Simple Steps **Real Results** with **TELE-APP**

TELE-APP gets your individual medical business done – **fast**. In just **3 simple steps** you get **3 real results**:

- 1 Less paperwork**
- 2 Quicker policy issue**
- 3 Commissions paid sooner**

What could be easier?

Three simple steps and you're ready to send in your first *TELE-APP* right away!

turn the page to begin!



FORTIS

Solid partners, flexible solutions®

John Alden is a
Fortis Health member company

3 Steps *Made Simple*

- 1** Complete the **Eligibility Review** form with your Individual Medical (IM) clients. If a person to be insured answers “yes” to any of the 8 questions on the Eligibility Review, do not proceed to Step 2 with that applicant.
- 2** Complete **Part 1** with your clients. Immediately fax pages 1 and 2 of Part 1 and the Software Proposal to **your North Star Marketing Office**. Be sure you and your clients sign the Conditional Receipt before you tear it off and leave it with them.
- 3** Prepare your clients for their Personal Health History Interview by giving them the **Applicant Instructions**. Applicants must call for their interview within 10 days to ensure the Conditional Receipt is valid.

Check it out – then check it off!

Use this easy checklist to make sure you’re not missing anything for *TELE-APP*.

- Are other IM underwriting forms required? Send them along with Part 1 and the Software Proposal.
- Our convenient Check-O-Matic is easier than ever! You don’t even need to send in a voided check. Just fill out the simple COM section on Part 1.
- If your client *must* pay with a mode other than COM, make sure you send that payment with Part 1 to ensure the Conditional Receipt is valid. Mail to your North Star office.
- One applicant needs to call in for the interview. Help your clients choose who’s best equipped to represent him/herself and all others applying for coverage.
- During the interview, your clients will speak directly with a Fortis Health representative. Have them ready to review medical history for the past 5-10 years* for everyone who’s applying. (*Check your state’s Underwriting Guidelines to determine the number of years’ history your clients should be prepared to review.)
- We need the details! Have your clients ready to provide details of medical conditions, including dates, doctors, treatment, medication, etc. There’s a convenient chart on the Applicant Instructions to help your clients capture this information.
- Does your client have other coverage? Have those with other insurance ready to provide details, including company name and phone number, type of coverage, dates, etc. You can capture that information on Part 1.
- You’ve prepared your clients for the call. Now give them the Applicant Instructions. **Call 1-866-737-4956** to begin the underwriting process.



**You've followed the steps *and* checked your list.
So now what?**

Underwriting makes a speedy decision and you're moving on to your next sale!

There are 4 possible outcomes

For **standard** underwriting offers:

you'll receive the policy in the mail for placement.
After your client signs the Acceptance of Offer
and Attestation, return it to us.

standard

For **requests** for medical records, labs or exams:

you'll receive a fax.

request

For **counter** underwriting offers:

you'll be contacted prior to the policy being
issued so your client can review the offer.

counter

For **declined** underwriting notifications:

you'll be contacted with details about the decline.

decline

So, that's TELE-APP!

In **3 Simple Steps**, you get **3 Real Results** – *what could be easier?*

TELE-APP

Eligibility Review for _____

Applicant name



Use this form to determine the eligibility of any person to be insured. Use the Ineligible Build, Occupation and Medical Conditions lists to help you answer the questions. You do not need to send this form in.

1. Does any person to be insured have or ever had any of the ineligible medical conditions listed on the back of this form? Yes No
2. Is any person to be insured over the acceptable height/weight ratio listed below? Yes No
3. Is any person to be insured employed in an ineligible occupation listed below? Yes No
4. Is the applicant, spouse or any of their dependents, regardless if applying for coverage, currently pregnant or an expectant parent? (If yes, neither parent is eligible to apply for coverage until after the pregnancy has ended. The mother and child can be considered after postpartum and well-baby check-ups, minimum 6 weeks later. The father is eligible to apply for coverage after the pregnancy has ended.) Yes No
5. Does any person to be insured have a pending doctor appointment (other than routine) or has diagnostic testing, treatment or surgery been recommended or scheduled that's not completed? Yes No
6. Is any person to be insured **not** a U.S. citizen or a foreign resident living in the U.S. under a form of immigrant Visa or has the person been in the U.S. less than one year? Yes No
7. Has any applicant age 55 or older **not** had a physical within the last 5 years? Yes No
8. Does any person to be insured have plans for extended travel? Yes No
9. Will any person to be insured become eligible for any other form of medical insurance in the next six months? Yes No

If you answered "yes" to any of the questions, the applicant will not be eligible to continue the application process. You can continue the process with other applicants who have not answered "yes" to any questions above, but it is not a guarantee of coverage. You can proceed with Part 1 for those eligible applicants. Please refer to your Underwriting and Administrative Guidelines for eligibility information about HIPAA and Basic and Standard Plans.

After completing Part 1, a review of the applicant's complete medical history will be performed during the Personal Health History Interview and is subject to underwriting rules and regulations. The applicant will need to provide detailed information regarding the medical history, including diagnosis of medical conditions, dates of treatment, and testing received (including date of full recovery, names and doses of medications, and names and addresses of medical practitioners).

Ineligible Build - Unisex - 16 years and over				Ineligible Occupation List
Height	Max. for Rating	Height	Max. for Rating	
4'10"	190	5'10"	277	Applicants recently laid off, temporarily unemployed or between jobs, or on medical disability are not eligible.
4'11"	197	5'11"	285	Air Traffic Controllers
5'0"	203	6'0"	293	Armed Forces personnel
5'1"	210	6'1"	301	Asbestos/toxic chemical workers
5'2"	217	6'2"	310	Divers (professional skin or scuba)
5'3"	224	6'3"	318	Explosive workers
5'4"	231	6'4"	327	Fishermen/Crew
5'5"	239	6'5"	336	Off-shore oil workers
5'6"	246	6'6"	345	Oil and natural gas workers, including off-shore operations
5'7"	254	6'7"	354	Professional Auto Racers
5'8"	261	6'8"	363	Rodeo Participants
5'9"	269			Professional athletes: Ballet, Baseball, Basketball, Football, Wrestling
				Professional Crop Duster
				Persons temporarily unemployed, laid off or between jobs
				Structural Steel workers
				Stunt Flyers
				Underground miners
				<i>Some state variations exist. See your Guidelines for more information.</i>



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Ineligible Medical Conditions

A

Addison's disease
Adult respiratory distress syndrome (ARDS) with severe respiratory impairment
AIDS
Alzheimer's disease
Amphetamine usage
Amyotrophic lateral sclerosis (ALS)
Aneurysms
Angina (unstable, variant, Prinzmetal, vasospastic)
Ankylosing spondylitis
Anorexia nervosa (up to 5 years decline; individual consideration thereafter)

Aortic arch arteritis
Aortic insufficiency
Aortic stenosis
Aortitis
Aplastic anemia
Aregenerative anemia
Arterial embolism (clot)
Arterial occlusion
Arteriosclerosis obliterans (ASO)
Arteriovenous malformation
Arteritis
Ataxia telangiectasia
Atherosclerosis obliterans
Atherosclerosis thrombotic disease
Atrial fibrillation – chronic
Autism

B

Banti's syndrome (spleen disorder)
Berger's disease
Bipolar disorders
Bladder extrophy (congenital malformation of the bladder wall)
Asymptomatic – permanent rider
Symptomatic – decline

C

Cancer (with lymph node involvement or metastasis)
Cardiac decompensation
Cardiac Defibrillator (implantable)
Cardiomyopathy
Cerebral palsy
Charcot's syndrome
Charcot-Marie tooth disease (if present)
Chediak Higaski syndrome
Christmas disease
Chronic Granulomatous disease
Chronic obstructive pulmonary disease (COPD)

Cirrhosis of the liver
Coarctation of the aorta
Cocaine abuser
Common Variable Immunodeficiency
Congenital lymphedema
Congestive heart failure (CHF)
Cor pulmonale
Coronary artery bypass surgery
Coronary artery disease (CAD)
Coronary heart disease (CHD)
Crohn's disease
Curvature of the spine (with pulmonary, cardiac or spinal cord involvement)
Cushing syndrome (caused by bilateral adrenal hyperplasia or administration of steroids to treat another disorder)
Cystic fibrosis
Cystic medical necrosis

D

Dejerine type sclerosis
Dementia
Depressant addiction
Depression – major (if hospitalization required)
Di George syndrome
Diabetes mellitus

E

Ebstein's malformation
Eisenmenger's complex
Eosinophilic granuloma
Eosinophilic granuloma of bone
Esophageal varices (varicose veins in the esophagus)
Ehlers-Danlos syndrome

F

Fabry disease
Factor VIII or IX deficiency (clotting disorder)
Fragilitas ossium

G

Gargoylism
Gastric bypass/stapling
Gaucher's disease
Gender identity
Gilles de la Tourette's syndrome
Glycogen storage disease

H

Hand-Schuller-Christian disease
Heart-lung transplants
Heavy chain disease
Hemiplegia

Hemochromatosis
Hemophilia A or B
Histocytosis X
Hodgkin's disease
Hydrocephalus
Hydronephrosis (bilateral)
Hypersplenism
Huntington's chorea
Hypoplastic anemia

I

IgG Subclass Deficiency
Ischemic heart disease

K

Kahler's disease
Kartagener's syndrome
Kidney transplant

L

Letterer-Siwe disease
Leukemia
Liver transplant
Lobstein's disease
Lou Gehrig's disease
Lymphoblastoma
Lymphomatoid Papulosis
Lymphoma

M

Marchiafava-Micheli syndrome
Marfan's syndrome
Marijuana usage (current or past history in conjunction with other drugs)
Mental retardation (severe, emotionally unstable seizures or psychiatric impairments)
Mesenteric vascular disease
Milroy's disease
Mitral insufficiency
Mitral stenosis
Mixed connective tissue disease
Mongolism
Mucopolysaccharidosis
Multiple myeloma
Multiple sclerosis
Muscular dystrophy
Myocardial infarction (MI)
Myocardial ischemia

N

Narcotic use/addiction
Nephrocalcinosis
Nephrosclerosis
Neurofibromatosis
Niemann-pick disease

O

Osteitis fibrosa cystica disseminate
Osteitis fibrosa cystica generalisata
Osteogenesis imperfecta

P

Pacemakers
Pancytopenia
Paralysis
Paranoid and other psychotic disorders
Paraplegia
Parkinson's disease
Paroxysmal nocturnal hemoglobinuria
Percutaneous transluminal coronary angioplasty
Periarthritis nodosa
Peripheral occlusive arterial disease (POAD)
Peripheral vascular disease
Personality disorders
Pituitary dwarfism
Plasmacytoma
Pneumocystitis carinii pneumonia (PCP)
Polyarteritis
Polycystic kidney
Polycythemia vera
Polyglandular autoimmune disease
Porphyria (diagnosed less than 5 years prior to application)
Primary pulmonary hypertension
Primary sclerosing cholangitis
Pseudothrombophilia
Psychedelics usage (LSD, PCP)
Psychiatric disorders – severe childhood and adolescence (including conduct & oppositional defiant.)
Pulmonary heart disease
Pulmonic insufficiency
Pulmonic stenosis
Pulseless disease

Q

Quadraplegia

R

Rhabdomyosarcoma

S

Sarcoma
Schizo-affective disorders
Schizophrenia
Scleroderma (systemic)
Severe combined immunodeficiency
Sick sinus syndrome
Sickle cell anemia

Silent Myocardial Ischemia
Spurway's disease
Stimulant usage (amphetamines, cocaine)
Stroke
Sturge-Weber syndrome
Suicide attempt
Syndrome X
Systemic lupus erythematosus

T

Takayasu's disease
Tetralogy of fallot
Thalassemia major
Total anomalous pulmonary venous connection
Tourette's syndrome
Transient ischemic attack (TIA)
Transplants (except corneal transplants)
Transposition of the great vessels
Transsexualism
Tricuspid atresia
Tricuspid stenosis
Trisomy 21 syndrome
Truncus arteriosus

U

Ulcerative colitis

V

Valve replacement
Vascular hemophilia
Ventricular arrhythmias
Von Hippel-Lindau syndrome
Von Willebrand's disease

W

Waldenstrom's macroglobulinemia
Wegener's granulomatosis
Wilson's disease
Wiskott aldrich syndrome

Tele-App Part 1 Application for Medical Insurance for Individuals and Families



Agent Information

Agency Name _____ **Agency Number** _____
Agent Name _____ **Agent Number** _____
Agent Fax Number _____ **Agent Phone Number** _____
Agent E-mail Address _____ **Sales Rep Number** _____

Person(s) To Be Insured

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number
(Primary)						
1.						
(Spouse)						
2.						
3. Dependent Children						
Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)

 Street City State ZIP

5. Home Phone Number _____ 6. E-Mail Address: _____

7. Are any of the proposed insureds covered by any type of medical insurance? Yes (complete section below)
 No (go to Billing)

Proposed Insured's Name	Insurance Company Name	Insurance Company Phone Number	Group (G) or Individual (I)	Type of Coverage	Effective Date	Term Date	Is this coverage being replaced by proposed coverage?

Billing

Check-O-Matic
 (Complete form on next page and authorization below)

I (we) hereby authorize John Alden Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X _____
 Signature of Payor

X _____
 Date Signed

Quarterly **Semi-Annual** **Annual**
 (If billing address is different than above, complete section below)

Name

Address

 City State ZIP



REMEMBER TO FAX PAGES 1 & 2, AND THE SOFTWARE PROPOSAL!

Authorization for Check-O-Matic Billing Only

Choose the following option that applies:

To begin Check-O-Matic withdrawals:

Select a desired withdrawal day: (1-28): _____

Bank Name _____

City _____ State _____

* **To add this policy to an existing Check-O-Matic:**

Existing COM Number _____

Associated Policy Number _____

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) 1234
	Date _____
Pay to the order of _____	\$ _____
	_____ Dollars
ANYTOWN BANK	
Memo _____	_____
123456789 (Routing Number)	0987654321 (Account Number)

EXAMPLE

Routing & Transit Numbers _____

9 Digits

Account Number _____

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

Authorization To Obtain Medical Records and Attestation

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give John Alden Life Insurance Company (or any consumer-reporting agency authorized by John Alden Life Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded personal health history, Part 1 and any amendments shall be the basis for the contract. I also agree that:

- (1)** I must call John Alden Life Insurance Company and complete the telephone portion of the application process within 10 days of commencement of the application process and subsequently provide any and all medical information related thereto.
- (2)** I understand that if at any time through the application process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact John Alden Life Insurance Company and advise of such change.
- (3)** Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the application form information with a signature and returning that signed acceptance to John Alden Life Insurance Company.
- (4)** Except as otherwise provided in the Conditional Receipt, the insurance, if approved by John Alden Life Insurance Company, will be in force only when issued by John Alden Life Insurance Company and accepted by me.
- (5)** I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker.
- (6)** If any of these conditions are not met, John Alden Life Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

Signature of Primary Proposed Insured

Signature of Spouse or Other Insured (if proposed to be insured)

(Circle one)
A.M. / P.M.

Date Signed

Time Signed

City & State

Requested Policy Effective Date

Conditional Receipt Given? **Yes** **No**

REMEMBER TO FAX PAGES 1 & 2, AND THE SOFTWARE PROPOSAL!

Conditional Receipt

This Conditional Receipt is received from _____, this _____ day of _____ month _____ year.

The proposed insured has authorized either an electronic transfer of funds or money in the sum of \$_____ for the necessary amount of premium and/or any administrative processing fees, that will be paid in connection with completing a medical insurance enrollment form with John Alden Life Insurance Company.

No insurance will become effective prior to contract issue and acceptance by the proposed insured, except, insurance may become effective prior to the contract issue if and when each and every condition contained in this receipt is met. No agent or broker of the company is authorized to alter or waive any of the following conditions:

1. The proposed insured(s) must be, on the effective date, as hereinafter defined, a risk acceptable to the company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of payment received with Part 1 or the actual withdrawal of funds by means of electronic transfer is an amount equal to the amount of the first full premium payment selected.
3. The proposed insured(s) must call John Alden Life Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto.
4. The contract is issued exactly as applied for within 30 days from the date of commencement of the enrollment process. If the contract is not issued within 30 days from the date of commencement of the enrollment process, there will be no coverage provided under the terms of this Conditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered and accepted by you.
5. Proposed insured(s) completes all forms and provides all information required through the application and enrollment process.
6. Part 1 is submitted by an insurance agent or broker appropriately licensed to do business with the company and in the appropriate state jurisdiction.
7. Proposed insured(s) understands that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, he or she has an obligation to contact John Alden Life Insurance Company and advise of such change. Failure to do so may result in claim denial or rescission/revocation of coverage.
8. Within 30 days of policy issue, the proposed insured must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning the signed acceptance to John Alden Life Insurance Company.

If each of the above conditions is fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the effective date prior to the contract delivery. "Effective Date" as used herein means the later of a) the date of commencement of the enrollment process, or b) the requested effective date. If one or more of the conditions are not met, John Alden Life Insurance Company may rescind its offer of coverage and its liability shall be limited to the return of the sum received.

Proposed Insured Signature

Agent Signature

Agent Name: _____
Last First



Agent Phone Number: _____

Personal Health History Interview Applicant Instructions

Thank you for your interest in our individual medical insurance. In addition to Part 1 that you completed with your agent, this Personal Health History Interview will help us determine eligibility for health insurance. One of our representatives will conduct your interview.

Just follow these easy steps for a quick and accurate interview:

- Choose one adult person who's applying for coverage to contact Fortis Health.
- Use this chart to provide information on all applicants:

APPLICANT(S)	CURRENT HEIGHT & WEIGHT	BLOOD PRESSURE & CHOLESTEROL READINGS	LAST PHYSICIAN VISIT DATE (PAP RESULTS FOR FEMALES)	MEDICAL CONDITIONS IN PAST 10 YRS.	DATES WHEN SPECIFIC MEDICAL CONDITIONS OCCURRED	PHYSICIAN NAMES AND ADDRESSES	TYPES OF TREATMENT & NAMES AND DOSES OF MEDICATIONS

- The caller will need to review the attached Medical Conditions list.** Please review all of the conditions and circle those that apply to each applicant. During your call, the representative will ask when the condition began, if it still exists and what type of treatment was provided.
- Call within 10 days of completing the application form with your agent.** This allows the terms of your Conditional Receipt to be honored.

- Allow 20 minutes for the call.** Interview time may vary based on the number of proposed applicants and the extent of their medical conditions.
- Dial 1-866-737-4956** to reach a representative for your interview.
- Your agent will contact you** following the interview. Eligible applicants will be asked to attest to the interview information in writing.

***Thank you again for choosing us for your health insurance.
Please keep this form for your records.***

Policies are issued and underwritten by John Alden Life Insurance Company, a Fortis Health member company, Milwaukee, Wisconsin.

MEDICAL CONDITIONS LIST

Please review the following medical conditions and circle any that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a physician for in the past 10 years. These conditions may be associated with the specific medical category under which they're listed. However, they are examples of the medical category and do not necessarily include all the conditions related to that category. Therefore, if you have a particular illness or condition which does not appear on the list or you are uncertain which category it's associated with, please tell your representative.

Lungs and Respiratory System

Hayfever/allergies	Tuberculosis	Emphysema
Sinus infections	Pneumonia	Sleep Apnea
Asthma	Pneumothorax	Chronic Obstructive Pulmonary Disease
Bronchitis	Other _____	

Ears/Eyes/Nose Disorders

Ear infections	Meniere's	Deviated Septum
Ear tubes	Tinnitus	Cataracts
Hearing loss	Labyrinthitis	Glaucoma
Speech/hearing impairment	Tonsils/adenoids	Other _____

Heart/Circulatory*

High blood pressure	Heart murmur	Elevated Cholesterol
Heart attack	Mitral valve prolapse	Peripheral vascular disease
Chest pain	Phlebitis	Irregular heart beat
Varicose veins	Other _____	

*Please provide the most current date and reading for blood pressure and cholesterol (including HDL, LDL and total cholesterol).

Blood pressure _____
Cholesterol _____

Diabetes/Thyroid

Diabetes	Hypothyroid	Goiter
High blood sugar	Low blood sugar	Hypoglycemia
Hyperglycemia	Hyperthyroid	Other _____

Blood/lymph/anemia

Anemia (type)	Swollen lymph nodes	Lymphadenopathy
Other _____		

Cancer

Provide location, type of cancer and any treatment received. If you do not know the specific diagnosis, contact your physician for that information.

Tumor/Cyst/Growth

Tumor	Cyst	Polyp
Growth	Other _____	

Breast

Breast Implants	Fibrocystic breast disease	Other _____
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Skin Disorders

Acne	Rosacea	Psoriasis
Skin cancer	Eczema	Other _____

Nervous System Disorders

Unconsciousness	Vertigo	Epilepsy/seizures/convulsions
Paralysis	Multiple Sclerosis	Headaches/Migraines
Cerebral palsy	Bell's palsy	TIA (transient ischemic attack)/brain attack
Stroke/mini-stroke	Parkinson's disease	Other _____

Mental/Nervous Disorders

Emotional disorder	Anxiety	Depression
Anorexia	Bulimia	Attention Deficit Disorder
Schizophrenia	Panic Attacks	Obsessive Compulsive Disorder
Dysthymia	Insomnia	Oppositional Deviant Behavior
Other _____		

Digestive Disorders

Ulcer	Gastritis	Heartburn
Intestinal disorder	Colitis	Gallbladder
Crohn's	Ulcerative colitis	Irritable Bowel Syndrome
Hemorrhoids	Hernia	Pancreas disorder
Spleen disorder	Liver disorder	Hepatitis
GERD	Jaundice	Cirrhosis
Other _____		

Bone/Muscle/Connective Tissue Disorders

Arthritis	Gout	Carpal tunnel syndrome
Low back pain	Fractures	Lupus/Systemic lupus erythematosus (SLE)
ACL tear	Spinal fusion	Joint replacement
Back/spine disorder	Manipulation therapy	Muscular/Neuromuscular disorder
Osteoarthritis	Herniated disc	Degenerative joint disease
Scoliosis	Sprain/Strain	Bunions
Bursitis/Tendonitis	Chronic Fatigue Syndrome	Other _____

Fixation /Prosthetic Device

Plates	Screws	Pins
Implants	Breast implants	Shunts
Pacemaker	Valve replacement	Joint replacement

Urinary System Disorders

Kidney stones	Cystitis	Bladder infections
Prostatitis	Glomerulonephritis	Nephritis
Kidney disorder	Other _____	

Reproductive System Disorders

Penis	Testes	Vagina
Ovaries	Cervix	Uterus
Infertility	Irregular Menses	Uterine fibroids
Endometriosis	Ovarian cyst	Sexually transmitted diseases (STDs)
Rectocele	Cystocele	Prolapsed uterus
PMS	Polycystic ovarian disease	Benign Prostatic Hypertrophy
Other _____		

Complications of Pregnancy

Ectopic pregnancy	Miscarriage	Pre-eclampsia
Gestational diabetes	Pre-term labor	C-section
Other _____		

Pap Smear (date of exam and results)

Cervical dysplasia	Cervicitis	Atypical squamous cells (ASCUS)
Inflammation	Cervical cancer	Other _____

Immune Deficiency

Swollen lymph nodes	Loss of appetite	Weight loss
Chronic fatigue	Fever	Oral thrush
Skin rashes	Unexplained infections	Dementia
Depression	Pneumonia	Psychoneurotic disorders

Congenital Disorders/Birth Defects/Developmental Disorders

Down syndrome	Mental retardation	Autism
Cleft lip/palate	Club foot	Congenital heart defects
Speech therapy	Occupational therapy	Physical therapy
Other _____		

Diagnostic Testing

EKG (electrocardiogram)	Chest x-ray	Echocardiogram
Stress test	Angiogram	MRI
CT scan	Ultrasound	Mammogram
Colonoscopy	EGD (endoscopy)	Holter monitor
EEG	Bone density	Urinalysis
Blood test		
Other _____		

Hazardous activity

Participation in any hazardous activity:		
Automobile racing	Motorcycle racing	Powerboat racing
Skydiving	Ultralight flying	Scuba diving
Hang gliding		

Driving record

Any adverse driving history:		
DUI (past 5 years)	Moving violations (past 2 years)	Speeding
Reckless driving		

Dates _____

Types of Violations _____

***** IMPORTANT *****

NEW HIPAA Regulation: Please have your client sign this form along with the completed application/enrollment form. If we do not receive this signed form, the underwriting process could be delayed.

Underwriting Authorization



Name of Proposed Insured(s): _____

Address: _____

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to John Alden Life Insurance Company, its legal representative or any medical records retrieval service John Alden Life Insurance Company may engage, including, but not limited to, EMSI.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKG's. This information may also be disclosed to any medical records company engaged by John Alden Life Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by John Alden Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable John Alden Life Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for John Alden Life Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, John Alden Life Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying John Alden Life Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Fortis Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if John Alden Life Insurance Company has taken action in reliance on the authorization. I understand that John Alden Life Insurance Company is a Fortis Health member company and that all references to John Alden Life Insurance Company in this authorization also includes Fortis Health.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of John Alden Life Insurance Company.

Signature of Primary Proposed Insured or representative*

Date

Signature of Spouse or Other Proposed Insured(s) or representative*

Date

Signature of Other Dependents 18 or Over (if proposed to be insured)

Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS



*John Alden is a
Fortis Health member company*