COMPLETECARE PERSONAL HEALTH PLANS - (Texas)

Underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri

ATTENTION PRODUCERS: Where do you want the Certificate of Coverage mailed? (Check one) Producer _____ Insured _____

SECTION 1: GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

APPLICANT'S NAME	LAST	FIRST	INITIAL	SOCIAL SECURITY NUMBER	
APPLICANT'S HOME ADDRESS (P.O. Box not acceptable)	STREET	CITY	STATE	ZIP CODE	
BILLING ADDRESS	STREET	CITY	STATE ZIP CODE	E-MAIL ADDRESS	
HOME PHONE NUMBER	WORK PHONE NUMBER	FAX NUMBER	BEST TIME FOR US TO CALL (HM) (WK)		
OCCUPATION (Title & Industry)	STATUS: Male Female Single Married	BIRTHDATE	AGE	HEIGHT FT IN	WEIGHT LBS

Dependent Information (Complete only for dependents to be covered under this plan.)

SPOUSE'S NAME	LAST	FIRST	INITIAL	SOCIAL SECURITY NUMBER	
SPOUSE'S OCCUPATION (Title & Industry)	HEIGHT FT IN	WEIGHT LBS	BIRTHDATE	AGE	

Dependents Name (First & Last)	Relation-ship	Sex	Birth Date/Age	Height	Weight	Full-time Student?	Dependents Name (First & Last)	Relation-ship	Sex	Birth Date/Age	Height	Weight	Full-time Student?

Has the Applicant or Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past 12 months? Types of tobacco/cessation products and the frequency of usage?

_____

Requested Effective Date (check one):

☐ I request the Company assign my effective date to be the 1st of the month following approval.

☐ I request an effective date of _____ (must be the 1st or 15th of the month). I understand I cannot change this date.

If the Company is unable to approve the application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Mode of Payment: ☐ Credit Card ☐ Bank Draft ☐ Direct Bill

Who is to be insured? (Check all that apply) ☐ Applicant ☐ Spouse ☐ Child(ren)

PPO Provider Network Selected:

PLAN SELECTION: ***Out-of-Network benefits differ from In-Network benefits. See brochure for details.***

☐ Copay Choice	☐ Copay Advantage	☐ Health Security	☐ Single Deductible	☐ Daily Deductible	☐ CompleteCare HSA
Copay: ☐ $35 ☐ $70 Deductible: ☐ $1,000 ☐ $3,500 ☐ $1,500 ☐ $5,000 ☐ $2,500 Coinsurance Limit: ☐ 80% to $10,000 ☐ 70% to $20,000	Deductible: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 Coinsurance Limit: ☐ 80% to $10,000 80% to $20,000 ☐ 70% to $10,000 70% to $20,000	Deductible: ☐ $2,000 ☐ $5,000 ☐ $7,500 ☐ $10,000	Deductible: *Single* / *Family* ☐$1,000 ☐ $2,000 ☐$1,700 ☐ $3,350 ☐$2,600 ☐ $5,150 ☐ HSA Submit attestation of HSA form	Daily Deductible: ☐ $250 ☐ $500	Deductible: *Single* / *Family* ☐$1,000 ☐ $2,000 ☐$1,700 ☐ $3,350 ☐$2,600 ☐ $5,150

Prescription Drugs

☐ **Rx Discount** – Discount Drug Benefit ☐ **Rx SAAOI** – Same as any other illness (Not available on Daily Deductible or 50-50 Share plans)

☐ **Rx Insurance** - Generic $25 / Formulary $100 / Non-Formulary $150

☐ **Rx Deductible 250** - Generic $15 / *$250 Brand Name Deductible, then:* Formulary $30 + 20% / Non-formulary $45 + 20%

☐ **Rx Deductible 500** - Generic $15 / *$500 Brand Name Deductible, then:* Formulary $30 + 20% / Non-formulary $45 + 20%

☐ **Rx Deductible 1000** - Generic $15 / *$1,000 Brand Name Deductible, then:* Formulary $30 + 20% / Non-formulary $45 + 20%

A. (Optional) 18-Month Rate Guarantee: ☐ Yes ☐ No (12-Month Rate Guarantee applies if not elected)

B. Wellness Coverage: ☑ Yes (Automatically included)

C. (Optional) Supplemental Accident: ☐ $500 ☐ $1,000

D. (Optional) Personal Assistance Program: ☐ Yes ☐ No

E. Sole proprietors, partners (ownership over 10%), or business owners who are not covered by Workers' Compensation are eligible for 24-hour occupational health insurance coverage. Do you qualify for this benefit? (Verification may be necessary.) Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

For Administrative Use Only

Case Number	Enter	Date	Approved By	Date	Eff Date	PCEFDT

CHECK ONE:
☐ SNA01SA ☐ NMA02SA
☐ PKZ99100 ☐ KOH00100
☐ CAM0100

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last) (First) (MI)	**Date of Birth** (Month/Day/Year)
1.	/ /
2.	/ /
3.	/ /
4.	/ /
5.	/ /
6.	/ /

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Fidelity Security Life Insurance Company ("FSL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit FSL, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: Date:

X_____ _____

X_____ _____

X_____ _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual: _____

IAC'S MONTHLY AUTOMATIC PAYMENT PLAN

To initiate the Automatic Payment Plan, the following must accompany your application:

- Credit Card Information;
  - OR -
- A voided check OR savings account deposit slip (business accounts not acceptable);
- This portion of the application must be fully completed and signed;
- A personal check made payable to Insurers Administrative Corporation for the initial premium. (Not required for Credit Card option.)

Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.

☐ **Credit Card Payment** Choose one: ☐ MasterCard ☐ Visa Initial Amount $_____

Name (as it appears on card)_____ Card#_____ Exp.Date____/____

Signature of Cardholder_____

☐ **Monthly Bank Draft**

Fidelity Security Life Insurance Company (FSL) or its authorized Administrator, Insurers Administrative Corporation (IAC), is hereby authorized to debit my checking or savings account on the first business day of each month until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued.

I further authorize the bank named below to pay and charge to my account those payments that are drawn on my account by FSL, and I agree that the bank named below shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify IAC in writing.

Signature of primary payer (or depositor if different) _____ Date ____/____/____

Name (please print) _____ Relationship to Applicant _____

Name of Bank _____ Address _____

Checking Account No. _____ Savings Account No. _____

SECTION 4: PRODUCER / GENERAL AGENT INFORMATION

Producer's Name _____ Company Name _____

IAC Producer # _____ Are you licensed in the state where the application was completed? ☐ Yes ☐ No

Are you currently appointed with FSL in the state where the application was completed? ☐ Yes ☐ No (If not, please refer to the Producers Guide for contracting rules.)

Address _____
Street City State Zip

Business Phone (____)_____ Fax (____)_____ E-Mail Address_____

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Fidelity Security Life Insurance Company.

_____ _____
Producer's Signature Date Date Application Sent to General Agent

General Agent's Name: _____

Group Warehouse Insurance Agency, Inc.
10210 N. Central Expressway Suite 216
Dallas, TX 75231 214-987-1266(phone)
214-987-1344(Fax)
IAC #0050361
rachel@groupwarehouseins.com

General Agent's IAC # _____

General Agent's Phone (____)_____

General Agent's E-Mail_____

_____ _____
Date Application Received by General Agent Date Application Sent to IAC

PRODUCER'S FINAL CHECKLIST

✓ Are all the questions answered and boxes checked?
✓ Has the applicant (and spouse, if applying) signed *both* Section 2 (Medical) and Section 3 (Agreement) on the application?
✓ Have you obtained a personal check from the applicant payable to Insurers Administrative Corporation?
✓ Have you offered the applicant the option of the Monthly Automatic Payment Plan?
✓ Has the applicant enclosed a voided check for the Monthly Automatic Payment Plan, if applicable?

Mail to:
INSURERS ADMINISTRATIVE CORPORATION
P.O. Box 37457, Phoenix, AZ 85069-7457
Fax No. (602) 861-6068

SECTION 3: APPLICANT AGREEMENT AND SIGNATURE

PREMIUM PAYMENT: I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) days grace period, coverage for all insured persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one day grace period will be refunded less any amounts due (if any) from previous months. I understand there is a one-time, non-refundable application fee.

CHOOSE A PAYMENT OPTION:

MODE:			METHOD: Bank Draft*	Credit Card*	Direct Bill
☐ Monthly	→ Choose Method →		☐	☐	☐
☐ Quarterly	→ Choose Method →		N/A	N/A	☐
☐ Semi-Annual	→ Choose Method →		N/A	N/A	☐

Complete IAC's Automatic Payment Plan Section of this application. Acceptable Credit Cards are MasterCard and Visa Only.

PRE-CERTIFICATION: I understand that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the Group Master Policy.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician or medical practitioner, hospital, medical facility, pharmacy benefit manager, laboratory, or other organization, institution, or person that has any medical information or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to Fidelity Security Life Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Insurance Company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to underwriting services, Pre-Certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review, claims processing or as may be otherwise lawfully permitted or required or as I further authorize. (Photocopy of this authorization shall be valid as the original. This authorization is valid for thirty (30) months from the date shown below.)

WORKING IN THE U.S.: I understand that the coverage under this plan is available for individuals who are legally working in the United States and benefits are not payable for medical expenses outside of the United States except when traveling.

INITIAL (APPLICANT MUST INITIAL EACH STATEMENT)

☐ **I AM AWARE OF THE PRE-EXISTING CONDITIONS LIMITATION PROVISIONS** I understand that my coverage and that of my dependents, if approved, will be subject to a pre-existing conditions limitation provision unless disclosed in the Medical History section of this application and not specifically excluded by name from coverage under the Group Master Certificate. No benefits will be payable for illness or injuries for which an individual received medical treatment (including the taking of medicine prescribed by a doctor), advice or consultation, during the 12 months immediately preceding the effective date of insurance until: (1) a 12-month period of continuous coverage under the plan during which no medical care or treatment was incurred for such illness or injury; or (2) a 24-month period of continuous coverage under this plan.

☐ **MY ANSWERS ARE TRUE AND COMPLETE.** I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete, and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information may be used as the basis of rescission of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to: a) waive, alter, or modify any question; b) permit me to inaccurately answer any question; or c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has the authority to alter the terms of the Group Master Policy.

☐ **APPLICATION FOR GROUP PLAN MEMBERSHIP.** I understand that I am applying as an individual for membership to the Multiple Unit Security Trust II and am simultaneously applying for insurance to which I am now or may become eligible for under the provision of the Group Master Policy issued to that Trust by Fidelity Security Life Insurance Company. I understand that my application is subject to medical underwriting and approval by Fidelity Security Life Insurance Company or its authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage. I understand that I am applying for medical insurance in a plan that is intended not to be an employer health plan. I certify the (a.) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents are paying any part of the premium either directly or through wage adjustments or otherwise, and (b) to my knowledge, my employer will not treat or represent this health plan as an employer- health insurance plan for any purpose, including a business tax deduction. Individuals not meeting this certification above are not eligible for this health plan coverage and are encouraged to talk to their producers about group coverage.

HIPAA Eligibility *(Must be completed if applying for coverage under HIPAA.)*

If this application is taken within the state of Texas and the applicant is eligible for HIPAA, ask your Producer about your Risk Pool options.

1. **Who is applying for HIPAA eligibility:** ❑ **Applicant** ❑ **Spouse**
2. Have you been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months? ❑ Yes ❑ No
3. What was the reason the coverage terminated under the most recent health insurance plan: _____ ❑ Yes ❑ No
   Was it for non-payment of premium? ❑ Yes ❑ No or Was it for fraud? ❑ Yes ❑ No
4. Was there a break in health insurance coverage in excess of 62 days during the past 18 months? ❑ Yes ❑ No
5. Are you eligible for or do you currently have group health insurance through your employer, your spouse's employer or as a dependent on any person's plan? ❑ Yes ❑ No
6. Are you currently eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID? ❑ Yes ❑ No
7. Was your most recent coverage under COBRA or any State or Federal Continuation plan? ❑ Yes ❑ No
   a. If "yes," when did coverage begin_____ and when will coverage be exhausted under such plan_____?
8. Was your current coverage a conversion plan elected through your previous carrier? ❑ Yes ❑ No

**** If you are applying for HIPAA coverage, please provide a copy of your Certificate of Creditable Coverage.***

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dated at _____ (City) _____ (State) on the _____ day of _____ (Month), _____ (Year).

_____ Signature of applicant (or parent if applicant is under age 18) Date

_____ Signature of spouse (if applying) Date

L. HEALTH HISTORY

INSTRUCTIONS: Please provide complete details to which any question is marked "Yes" in the appropriate space provided. We may need to request additional information regarding your health history from you or your attending physician. To help reduce those requests you may complete the *HEALTH HISTORY QUESTIONNAIRE* form for any "yes" responses noted.

Ques. No.	Person's Name	Condition(s) and Treatment	Date of Onset/ Last Office Visit Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals

M. MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

Please list all medications prescribed or taken by you or your dependents currently and in the past 12 months.

Ques. No.	Person's Name	Medications	Frequency & Dosage	Length of time on medication	Date medication was last taken	Complete Names and Addresses of Physicians

N. SIGNATURE

Signature of Applicant (and parent, if applicant is under age 18) _____ Signature of Spouse _____ Date _____

Other Coverage *(Must be completed for the application to be processed.)*

Are you or any dependents replacing other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following information:
Carrier Name: _____ Policy No. _____ Effec. Date: _____ Termination Date: _____
Was this an employer-sponsored group health plan? ☐ Yes ☐ No Is it your intent to be considered under HIPAA provisions? ☐ Yes ☐ No
If yes, you must complete the HIPAA Eligibility Section below in *Section 3* of this application.

SECTION 2: EVIDENCE OF INSURABILITY

A. ☐ Yes ☐No Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain

B. ☐ Yes ☐No Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in Sections L and M:

C. ☐ Yes ☐No Have you or any of your eligible dependents received disability benefits? If yes, list names and type of coverage:

D. ☐ Yes ☐No Has any person to be insured ever been diagnosed or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession? If yes, list names:

E. ☐ Yes ☐No Has anyone to be insured had breast, pin or plate implants? If yes, list names and provide details in Sections L and M:

F. ☐ Yes ☐No Are you, your spouse, or any dependents now pregnant or an expectant parent, whether applying for coverage or not? If yes, list names and provide details in Sections L and M: _____

G. ☐ Yes ☐No Are you or your dependents currently taking or have you been prescribed medications within the past 12 months? (List details/medications in Sections L and M.)

H. ☐ Yes ☐No Have you or your dependents previously applied for coverage with Insurers Administrative Corporation? If yes, list policy #: _____

I. ☐ Yes ☐No Have you or your dependents been hospitalized within the last 7 years? If yes, list names and provide details in Sections L and M.

J. Within the past seven years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

1. Abnormal Test Results	☐ Yes ☐No	22. Eye Disorders	☐ Yes ☐No	39. Muscular Dystrophy/ Cerebral Palsy	☐ Yes ☐No
2. Alcoholism/Alcohol Abuse	☐ Yes ☐No	23. Fractures/Dislocations	☐ Yes ☐No	40. Neurological Disease	☐ Yes ☐No
3. Allergies	☐ Yes ☐No	24. Gallbladder Disorder	☐ Yes ☐No	41. Pap Smear, Abnormal	☐ Yes ☐No
4. Arthritis or Rheumatism	☐ Yes ☐No	25. Headaches/Migraine	☐ Yes ☐No	42. Paralysis	☐ Yes ☐No
5. Asthma/Respiratory Disorder	☐ Yes ☐No	26. Heart Disorder/Murmur/ Heart Attack/ Coronary Artery Disease	☐ Yes ☐No	43. Prostate/Rectal Disorder	☐ Yes ☐No
6. Back/Muscle or Joint Disorder	☐ Yes ☐No			44. Reproductive Organs Disorder/ Endometriosis	☐ Yes ☐No
7. Bladder Disorder	☐ Yes ☐No			45. Sexually Transmitted Diseases	☐ Yes ☐No
8. Blood Disorder/Hemophilia	☐ Yes ☐No	27. Hepatitis: A☐ B☐ C☐	☐ Yes ☐No	46. Sinus Disorder	☐ Yes ☐No
9. Bone Disease/Deformity	☐ Yes ☐No	28. Hernia	☐ Yes ☐No	47. Skin Disorder	☐ Yes ☐No
10. Breast Disorder/ Fibrocystic Breast Disease	☐ Yes ☐No	29. High Blood Pressure/ Hypertension	☐ Yes ☐No	48. Sleep Disorders	☐ Yes ☐No
11. Cancer	☐ Yes ☐No	30. High Cholesterol	☐ Yes ☐No	49. Spinal Disorder/Back/Neck Strain	☐ Yes ☐No
12. Colitis, Spastic Colon, Polyps	☐ Yes ☐No	31. Infertility Testing/Treatment	☐ Yes ☐No	50. Stroke	☐ Yes ☐No
13. Congenital Disorder	☐ Yes ☐No	32. Kidney Disorder	☐ Yes ☐No	51. Thyroid or Goiter	☐ Yes ☐No
14. Cystic Fibrosis	☐ Yes ☐No	33. Liver Disorder	☐ Yes ☐No	52. Transplants	☐ Yes ☐No
15. Diabetes/Pancreatic Disorders	☐ Yes ☐No	34. Lupus/Systemic or Discoid	☐ Yes ☐No	53. Tuberculosis	☐ Yes ☐No
16. Digestive Disorder/Reflux	☐ Yes ☐No	35. Lymphadenopathy/ Immune Disorder	☐ Yes ☐No	54. Tumors/Cysts/Polyps/Growths	☐ Yes ☐No
17. Drug Addiction	☐ Yes ☐No	36. Menstrual Disorder	☐ Yes ☐No	55. Ulcerative Colitis/Crohn's/ Regional Ileitis	☐ Yes ☐No
18. Ear/Throat Disorders	☐ Yes ☐No	37. Mental, Nervous, Emotional Disorder/ Anxiety/Depression/ Attention Deficit Disorder	☐ Yes ☐No	56. Ulcers	☐ Yes ☐No
19. Eating Disorder/Anorexia/ Bulimia	☐ Yes ☐No			57. Urinary Tract Disorder	☐ Yes ☐No
20. Emphysema/Lung Disorder/COPD	☐ Yes ☐No	38. Mental Retardation/ Down's Syndrome	☐ Yes ☐No	58. Vascular Disorder	☐ Yes ☐No
21. Epilepsy and/or Seizure	☐ Yes ☐No			59. Other	☐ Yes ☐No

K. SIGNATURE

_____ _____ _____
Signature of Applicant (and parent, if applicant is under age 18) Signature of Spouse Date