# HERMANN SONS LIFE

## Waiver of Premium Rider Payor Information

### PAYOR'S NAME

PLEASE PRINT IN BLUE OR BLACK INK ONLY

FULL NAME (Last, First, Middle) | PAYOR'S DATE OF BIRTH

PROPOSED INSURED'S NAME | PAYOR'S SOCIAL SECURITY NO. | PAYOR'S PICTURE ID NO. | ID TYPE

### PAYOR'S MEDICAL INFORMATION

| | YES | NO |
|---|---|---|
| 1. (a) Exact Height ____ ft. ____ in.<br>(b) Weight ____ lbs. | | |
| 2. Have you gained or lost weight within the last two years? ☐ Gained ☐ Lost (If "YES", give amount and reason.) | ☐ | ☐ |
| 3. Have you ever had a life insurance application declined, postponed, rated, modified, or withdrawn? (If "YES", give name of company(ies), date and reason.) | ☐ | ☐ |
| 4. Within the last five years, has the proposed insured been cited for DUI or reckless driving or other moving violations? If "YES", give driver's license number and please explain: | ☐ | ☐ |
| 5. Have you ever used or are currently using addictive or self-prescribed drugs? (Examples include cocaine, heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs.) (If "YES", give type and amount of daily usage.) | ☐ | ☐ |
| 6. Have you ever been treated for, received counseling, been advised to seek counseling, or joined a support organization because of ALCOHOL or DRUG usage? (If "YES", explain and give name and address of doctor.) | ☐ | ☐ |
| 7. Have your PARENTS, BROTHERS or SISTERS ever had diabetes, cancer, high blood pressure, heart disease or a congenital disorder? (If "YES", give relationship, condition, age at diagnosis and current age or age at time of death.) | ☐ | ☐ |
| 8. Have you ever been treated or evaluated at a hospital, clinic or other facility, or been advised to have any test or surgery not yet completed? (If "YES", explain.) | ☐ | ☐ |
| 9. Have you had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC"), or AIDS related conditions? | ☐ | ☐ |
| 10. Have you received treatment by a member of the medical profession in connection with any of the categories mentioned in (9)? | ☐ | ☐ |
| 11. Have you ever tested positive for antibodies to the AIDS (Human T-cell Lymphotropic Type III; HTLV-III) virus? | ☐ | ☐ |
| 12. Have you ever had, been told you had or ever been treated for: | | |
| a) Any disorder of the heart, circulatory, blood or immune system? (Examples include chest pain, heart murmur, heart attack, abnormal heart beat, high blood pressure, varicose veins, shortness of breath, disorder of blood vessels, anemia, etc.) | ☐ | ☐ |
| b) Cancer, tumor, cyst, growth or enlargement of the lymph gland? | ☐ | ☐ |
| c) Any disorder in breathing or of the respiratory system? (Examples include allergies, asthma, bronchitis, emphysema, tuberculosis, or other lung disorders.) | ☐ | ☐ |
| d) Any disorder of the digestive system, such as disease of the stomach, intestines, rectum, liver, gallbladder, esophagus, diarrhea of more than one week's duration, ulcer, hermorrhoids, polyps or hernia, etc.? | ☐ | ☐ |
| e) Any disorder of the urinary system? (Examples include references to the urinary organs or functions such as albumin, blood, sugar or pus in the urine; diseases of the kidney, bladder, etc.?) | ☐ | ☐ |
| f) Any disorder of the endocrine/hormone systems? (Examples include diabetes, thyroid, adrenal, pituitary or other glandular disorders.) | ☐ | ☐ |
| g) Any disorder of the nervous system, such as epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, nervousness, mental disorder, or received psychiatric treatment or attempted suicide, etc.? | ☐ | ☐ |
| h) Any disorder of the muscles, skin or bone? (Examples include gout, arthritis, collagen disease (connective tissue disease), disorders of the back, joints, extremities, muscles, etc.; or received chiropractic or therapist consultation.) | ☐ | ☐ |
| i) Any disorder or the male or female reproductive organs? (Examples depending on gender include menstrual disorder, complications of pregnancy, Caesarean section, or prostate disorder, etc.) | ☐ | ☐ |
| j) Any disorder of eyes, ears, nose or throat? (Except for cataracts, not necessary to include vision corrected with glasses or contact lenses.) | ☐ | ☐ |
| 13. Do you currently or have you ever used tobacco in any form? If "YES," give type, amount and dates used. | ☐ | ☐ |

| NAME AND ADDRESS OF ALL PHYSICIANS CONSULTED IN LAST 5 YEARS AND DETAILS OF EACH "YES" ANSWER FROM ABOVE | | | | | | |
|---|---|---|---|---|---|---|
| QUES. NO. | DISEASE OR DISORDER | NAME OF MEDICATION | DATE BEGAN MO/YR | DATE ENDED MO/YR | RESULTS | PRINT FULL NAME, ADDRESS & PHONE NO. OF PHYSICIANS & HOSPITALS |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## PAYOR'S PRIMARY CARE PHYSICIAN

NAME

ADDRESS

CITY STATE ZIP

PHONE NO.

## PAYOR'S LIFESTYLE & HAZARDOUS ACTIVITY INFORMATION

14. Have you been a pilot or student pilot, crew member or had any duties on board an aircraft in flight during the past 3 years? ***If, "YES", complete the Aviation Questionnaire.*** ☐ Yes ☐ No

15. Have you engaged in any hazardous activities during the past 3 years? Yes ☐ No ☐ If "Yes", Complete the following:

| **(a)** SCUBA DIVING | **(b)** PARACHUTING | **(c)** RACING | **(d)** OTHER - GIVE DETAILS |
|---|---|---|---|
| Depth of dives | Jumps per year | Type of vehicle | |
| No. of times per year | Total no. of jumps | Type of race course | |
| Name of Club | Name of Club | No. of races per year | |
| Type Certification | Type Certification | Type Certification | |
| Date of last dive | Date of last jump | Date of last race | |

16. Do you plan on any foreign travel? ☐ Yes ☐ No
If "Yes," give reason, destination and length of stay:

## SIGNATURES

**BEFORE SIGNING, PLEASE READ THE FOLLOWING:**

I, the payor, hereby certify that the statements and answers in this Waiver of Premium Application and any supplements or amendments thereto, are made by me and are complete and true, that they are correctly and fully recorded, and that no material circumstances or information has been withheld or omitted concerning my past and present state of health and habits of life.

I acknowledge receipt of the **NOTICES TO PAYOR**, Parts One and Two.

**AUTHORIZATION TO RELEASE INFORMATION**

The undersigned proposed payor hereby authorizes any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc., or other organization, institution or person, that has any records or knowledge of the payor or the payor's health, to give to HERMANN SONS LIFE, or its reinsurer(s), any such information. The undersigned payor also authorizes HERMANN SONS LIFE, or its reinsurers, to make a brief report of the payor's personal health information to MIB, Inc.

Signed at ____, Texas, this ____ day of, ____ 20 ____

Payor **X**

Witnessed by ____ Agent Signature

AGENT'S NAME (Please print)

AGENT'S NO.