

Date: _____

Employer Name: _____

Employee Name: _____

Date of Application: _____

Have you or any dependents received treatment for a condition, or has there been any change in health status, since the date you completed the American Community application?

Yes*

No

If yes, please provide details in the box below:

Person	Ht./Wt.		Diagnosis	Dates		Treatment or Surgery	Prescription and Dosage	
				From	To			

* A more detailed medical questionnaire may be required by underwriting.

Employee Signature

Date

Spouse Signature

Date