Statement of Disability Insurance Applicantâ€™s Health History

I. Personal Information

Full Name

Date of Birth

Gender Select

Address

Phone Number

Email

II. Physician Information

Primary Care Physician Name

Physician Phone

Date of Last Visit

Physician Address

III. Medical History

List any current or past medical conditions, illnesses, or hospitalizations:

Condition/Illness	Date Diagnosed	Treatment/Medication	Current Status

Have you been hospitalized in the past 5 years? If yes, please provide details:

IV. Lifestyle Information

Do you smoke? Select

Do you consume alcohol? Select

Do you exercise regularly? Select

Other relevant lifestyle or health habits:

V. Declaration

I certify that the information provided above is true and complete to the best of my knowledge.

Applicantâ€™s Signature

Date