HEALTH CERTIFICATE

Foundation Life Insurance Company of Arkansas

109 North 6th Street - Fort Smith, AR 72901
(479) 785-1714 or 1-800-446-2214

PLEASE PRINT

1. Name of Applicant (Last, First, Middle)	2. Date of Birth (Mo. Day Year)	3. Age Nearest Birthday	4. Place of Birth
5. Home Address (Street, City, State, County)		6. Sex ☐ Male ☐ Female	7. Marital Status ☐ Married ☐ Single
8. Name and address of employer	9. Occupation (Describe general duties)		
10. Name of Creditor			

11. Height and Weight_____

12. During the last five years have you been hospitalized or have you consulted a physician or practitioner for any disease or disorder? ☐ Yes ☐ No
    If yes, please explain _____

13. Have you ever been treated for or advised that you had any of the following:
    Nervous Disorder, Heart, Lung, High Blood Pressure, Cancer, Tumors, Diabetes, or Kidney Disorder?
    ☐ Yes ☐ No
    If yes, please explain_____

14. Have you ever been turned down or have you been charged a higher than standard rate for life or health insurance by any company? ☐ Yes ☐ No
    If yes, please explain_____

15. Are you presently retired from or restricted in any full time active employment because of your health?
    ☐ Yes ☐ No
    If yes, please explain_____

16. Please list name and address of personal physician along with any medications you are taking: _____

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_____

I hereby declare that all declarations, statements, and answers written or printed on this application are full, complete, and true to the best of my knowledge and belief. I declare that on the date hereof I was indebted to the above named Creditor in an amount at least equal to the amount of insurance provided for. **I DECLARE THAT ON THE DATE OF THIS APPLICATION I AM IN GOOD SOUND HEALTH.**

AUTHORIZATION

"I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health to give to Foundation Life insurance Company of Arkansas, or its reinsurer(s), any such information. I acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau. A photographic copy of this authorization shall be as valid as the original."

Agent _____
Witness to Signature

Signature of
Proposed Insured _____
Signature in Full

Date _____