

# **APPLICATION TO THE First Catholic Slovak Ladies Association**

Part I  
Please Print

1.) Full Name of Proposed Insured: \_\_\_\_\_  
 2.) Address: \_\_\_\_\_  
 3.) Birthdate: \_\_\_\_\_  
 State: \_\_\_\_\_ Male ☐ Single ☐ Widowed ☐  
 Female ☐ Married ☐ Divorced ☐

## **INSURABILITY**

1.) Has the proposed insured ever had any disease or disorder of: (If yes, circle condition and give details in No. 4)

a. Nervous system, epilepsy, or paralysis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Heart or blood vessels; chest pains, high or low blood pressure, rheumatic fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Stomach, liver, intestines, gall bladder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. Kidney, urinary, bladder, prostate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e. Lungs; asthma, tuberculosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

2.) Has proposed insured ever had symptoms of or been affected with: (If yes, circle condition and give details in No. 4)

a. Cancer, tumor, diabetes, glands, or blood disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Any serious illness, disease or injury not already listed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Consultation, treatment or examination by physician or any practitioner for any other reason?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

3.) Height: \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs. Weight gained/lost in past year (REASON): \_\_\_\_\_

4. Give complete details of any "YES" answers to Questions 1 and 2. Give the full names and addresses of physicians seen or hospitals used within the last 5 years. Include dates, nature of disease or injury and treatment.

5.a) Family Record	Living		Dead	
	Age	Chronic Health Condition	Age at death	Cause of Death
Father				
Mother				
Brothers/Sisters				

5b.) Have your parents, brothers, or sisters ever had heart disease, diabetes, cancer, or mental illness? Yes ☐ No ☐  
 If yes, please explain: \_\_\_\_\_

6.) In the past 5 years, have you used: Details of Yes Answer: \_\_\_\_\_  
 a. Alcoholic beverages? Yes ☐ No ☐  
 b. Narcotic drugs? Yes ☐ No ☐

7.) In the past 10 years, have you been treated for alcoholism or any drug habit? Yes ☐ No ☐  
 If yes, please explain: \_\_\_\_\_

8.) In the past 10 years, have you been in a hospital, clinic, mental hospital, or institution for examination, observation, diagnosis, operation, or treatment? Yes ☐ No ☐ If yes, please explain: \_\_\_\_\_

9a.) Are you now a cigarette smoker? Yes ☐ No ☐ If yes, please explain: \_\_\_\_\_  
 b.) Have you been a smoker and quit? Yes ☐ No ☐  
 c.) Did you quit within the past 6 months? Yes ☐ No ☐  
     6 months to 1 year ago? Yes ☐ No ☐  
     more than 1 year ago? Yes ☐ No ☐  
 d.) Did, or do, you smoke more than one pack daily? Yes ☐ No ☐

10.) Has the proposed insured had life or health insurance rejected, rated up, postponed, modified, cancelled, or not renewed? Yes ☐ No ☐ When? \_\_\_\_\_ What Company? \_\_\_\_\_

I hereby agree that the above questions and answers shall form Part Two of my pending application for insurance in the FIRST CATHOLIC SLOVAK LADIES ASSOCIATION.

I expressly waive on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder all provisions of law for bidding any physician, hospital official or employee, or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto, and I expressly authorize such persons to make such disclosures, all to the extent permitted by law.

Dated this \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Paramed Examiner or Physician

\_\_\_\_\_  
Signature of Proposed Insured (Parent or Guardian if Proposed Insured is under the age of 16)

# Emergency Room Discharge Papers

**Markus Reuber, Gregg  
Rawlings, Steven C. Schachter**



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