

Neoplasm Questionnaire (cont'd)

Please check the illnesses below that you have ever had:			
<input type="checkbox"/> Stroke	Year.....	<input type="checkbox"/> Edema	Year.....
<input type="checkbox"/> Heart Rhythm Problem	Year.....	<input type="checkbox"/> Eye trouble	Year.....
<input type="checkbox"/> Liver Problem	Year.....	<input type="checkbox"/> Ulcer Disease	Year.....
<input type="checkbox"/> Kidney Disease	Year.....	<input type="checkbox"/> Other?.....	Year.....
Do other members of your family have Cancer? please list the cause of the death)		Yes <input type="checkbox"/> No <input type="checkbox"/> (if a parent is deceased,	
If yes, who and what is the type? - -			

Attending Physician:-----

Date -----/-----/-----

I hereby, give full and irrevocable authorization to the Insuranec Company, to the Administrator and to MedNet Delegates' (Physician and Nurses), to inquire about my actual state of health and that of my dependants from any Medical Center or Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company, the Administrator and MedNet Delegates'. Failure to disclose material information, whether by omission or false declaration, which the Insurance Company should have known, the latter will have the right to cancel my or my dependents' rights in coverage starting from the effective date of the policy without having any financial obligation.

Insured's Signature:-----

Date -----/-----/-----