



8. Have you smoked within the last 12 months?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
9. Have you ever had any life or medical insurance rejected, canceled, issued on special terms, or declined on renewal?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
10. Do you have other medical insurance?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

If any of the answers to questions 1 to 10 is "Yes" please provide the following details:

<ul style="list-style-type: none"> <li>• Questions 1-3: Provide diagnosis or condition or problem, dates of occurrence, treatment and/or medication received, and results.</li> <li>• Question 4: Provide diagnosis, condition, or problem.</li> <li>• Question 6: Identify family member, disorder, and age at death.</li> <li>• Question 7: List medications including name, dose, and how often.</li> <li>• Question 8: State how many cigarettes/cigars per day, and for how many years you have smoked.</li> <li>• Question 9: Provide details.</li> </ul>		
Question No.	Name of Person	Details

Attach a separate sheet if more space is needed.

**DECLARATION**

I declare on behalf of myself and all other persons seeking insurance that to the best of my/our knowledge and understanding, the above statements are complete and true. I/we have not withheld any information concerning the past or present state of my/our health. I/we agree that the answers provided above shall be the basis for issuance of the policy and that any false, incorrect, or misleading statements may render this insurance null and void. If accepted, this application becomes part of the insurance policy.

If including children, I certify that all of my eligible children are included in this application.

I/we understand that the insurance will not take effect until policy effective date, which will require the acceptance of this application, full payment of the subscriber fee and issuance of the policy. Furthermore, I/we understand that if this application is accepted, there will be a 90 day waiting period before the effective date of the insurance. I/we also understand our obligation to immediately advise the company of any material change in the health of any applicant prior to the effective date and that the failure to do so may render this insurance null and void.

I understand that policy is subject to Pre-Existing Condition Exclusion.

In the event of a claim against the policy, I acknowledge that PGH has the right to obtain all prior medical records.

\_\_\_\_\_

Signature of Applicant \_\_\_\_\_  
Date

\_\_\_\_\_

Signature of Spouse (required if spouse is to be insured) \_\_\_\_\_  
Date

**PAYMENT**  MasterCard  Visa  American Express

I Authorize PGH Insurance Services, Ltd to bill my account for US \$ \_\_\_\_\_

CARD Number: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_ (mm) 20\_\_(yy)

Name as it appears on card: \_\_\_\_\_ Signature: \_\_\_\_\_

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Official Use S.C. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Plan _____ Code _____	Approved By _____ Date _____
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