

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
1 COLUMBUS PLAZA
NEW HAVEN, CONNECTICUT 06510-3326

MEDICAL QUESTIONNAIRE

To be completed by the medical examiner in his or her own handwriting and signed by the Proposed Insured in the presence of and witnessed by the medical examiner.

PLEASE PRINT ALL ANSWERS

Proposed Insured	(Last-First-Middle Initial)	Council No.	Birth Date	
			Month	Day Year
Address		(Street-City-State/Province)		Zip/Postal Code

1. a. Name and address of your personal physician? (If none, so state.)
 b. Date and reason last consulted?
 c. What treatment was given or medication prescribed?

2. To the best of your knowledge and belief do you have, or have you ever had or been treated for: (Circle applicable items and give details.)
- | | Yes | No | Details of "Yes" answers. (Identify question. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.) |
|---|--------------------------|--------------------------|---|
| (a) Disorder of eyes, ears, nose or throat?..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Dizziness, fainting, convulsions, frequent headache, paralysis or stroke, mental or nervous disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| (c) Shortness of breath, persistent hoarseness, cough or bronchitis, blood in sputum, asthma, emphysema, tuberculosis or other disorder of the respiratory system?..... | <input type="checkbox"/> | <input type="checkbox"/> | |
| (d) Chest pain, irregular heart beat or rhythm, high blood pressure, rheumatic fever, murmur, heart attack or other disorder of the heart? . | <input type="checkbox"/> | <input type="checkbox"/> | |
| (e) Chronic indigestion, jaundice, intestinal bleeding; ulcer, colitis, diverticulitis, or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (f) Sugar, albumin, blood or pus in urine; stone or other disorder of the kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (g) Diabetes; thyroid or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (h) Neuritis, sciatica, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (i) Blood clots, occlusions or any other disorder of veins or arteries? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (j) Tumor, cancer, disorder of skin or disorder of lymph glands? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (k) Anemia, leukemia, coagulation disorders or any other blood disorders, except HIV status? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (l) Use of habit-forming drugs/medication or use of alcohol considered by authorities to be harmful to one's health? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (m) Any other mental or physical disorder not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | |
3. (a) Have you had any change in weight in the past year? Yes No
 (b) Are you now under regular observation or taking treatment?..... Yes No
4. Other than as stated in answers above, have you within the past 10 years:
- | | | |
|--|--------------------------|--------------------------|
| (a) Had a checkup, consultation, illness, injury or operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Been a patient in a hospital, clinic, sanatorium or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Had an electrocardiogram, X-ray or other diagnostic test?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
5. Family history: (any history of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide.)

	AGE	IF LIVING	IF DECEASED	IF DECEASED
		STATE OF HEALTH (IF POOR, GIVE REASON)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers and Sisters				

- | | Yes | No |
|---|--------------------------|--------------------------|
| 6. Have you used tobacco, in any form, within the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever requested or received a pension, benefits or payment because of a bodily injury, sickness or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Females only: | | |
| (a) Have you ever had any abnormality of menstruation, pregnancy or disorder of the female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Are you now pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce the Knights of Columbus to issue the insurance applied for.

Signed at _____

_____ Date

Signature of Proposed Insured

Witness: _____
Signature of Medical Examiner

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus known as human immunodeficiency virus (HIV). To evaluate your insurability, the Knights of Columbus asks that you provide a sample of your blood for testing and analysis to determine the presence of HIV antibodies. (These are organisms produced by the body to fight the human immunodeficiency virus.)

By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test results. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure. The first test is known as the ELISA test. If positive, the ELISA test is repeated. If the second ELISA test is positive, a third test, known as the Western Blot test, is performed. If all three tests are positive, the laboratory will notify the Knights of Columbus.

All test results are required to be treated confidentially. Test results will be reported by the laboratory to the Knights of Columbus which will disclose them to those employees who have the responsibility to make underwriting decisions on its behalf. The Knights of Columbus may also disclose test results to outside legal counsel who need such information to effectively represent it in regard to your application. Also, the test results will be reported to the Medical Information Bureau, an insurance information exchange organization, and to reinsurers involved in the underwriting process. Test results reported to the Medical Information Bureau and reinsurance companies will be reported under procedures that are designed to assure confidentiality, including the use of a nonspecific blood test result code which does not indicate that you were subject to HIV testing. The test results may also be used for the preparation of statistical reports that do not disclose the identity of any particular person.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application will probably be declined, if your test results are positive. Also, other insurers to whom you may apply for insurance coverage in the future will probably require an AIDS-related blood test when they are notified that a nonspecific blood disorder has been reported to the Medical Information Bureau.

If your test results are reported by the laboratory to the Knights of Columbus as being positive, you are entitled to that information. A trained person should deliver that information, so that you can understand clearly what the test results mean. Therefore, you are asked to list below a physician, so that you can be notified of positive test results.

Name: _____

Address: _____

If you want to have the results of the test reported directly to you, initial here: _____. The results will be sent to you by registered mail with delivery restricted to you only.

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing and the information on the reverse side of the form. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I understand that a photocopy of this consent will be as valid as the original.

Important: Before signing this form, please read the information on the reverse side.

Signature of Proposed Insured

Date