

Navy Mutual Medical Questionnaire



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NOTE: Please complete the following Medical Questionnaire as requested. If you are completing a convertibility application and would like to qualify for Select or Super-Select rates on Navy Mutual Aid Association's Level II 'Plus' Term Benefit Plan, you will also need to provide us with a copy of your most recent physical examination, no more than 12 months old, to include blood, urine, and EKG results.

Member's Name _____ Height (in.) _____ Weight (lbs.) _____

Spouse's Name _____ Height (in.) _____ Weight (lbs.) _____

Medical Questionnaire: Have you or any proposed insured had or been treated for any of the following?		Insured		Spouse		Children	
		Yes	No	Yes	No	Yes	No
1.	High blood pressure, shortness of breath, chest pain, heart attack, stroke; palpitations, heart murmur; anemia or any disease of the blood, blood vessels, or heart						
2.	Tuberculosis, asthma, emphysema, bronchitis, pleurisy, or any disorder of the lungs; disorder of the thyroid or other glands						
3.	Convulsions, epilepsy, stroke, loss of consciousness, paralysis, dementia, brain disorder, nervous disorder, or mental health disorder						
4.	Diabetes; albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate						
5.	Hepatitis, ulcer, jaundice, gall stones, chronic diarrhea, or any digestive or intestinal disorder						
6.	Growth, tumor, malignancy or cancer; disease of the skin, bones or joints; arthritis or rheumatism						
7.	Any illness or injury (other than minor colds or flu) for which a physician or other practitioner was consulted; disease or physical deformity; or surgical procedure or hospitalization						
8.	Alcoholism, excessive use of alcohol; use of cocaine, barbiturates, amphetamines or any other habit forming drugs except as prescribed by a licensed physician						
9.	Any disease or disorder resulting in rejection, higher premiums, or a reduction in insurance by another insurer						
10.	Any medications taken within the past year (prescription, over the counter, herbal). List below with dosages, dates, and diagnosis/reason taken						
11.	Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions						
12.	Tested positive for HIV (AIDS) antibodies (unless prohibited by law)						
13.	Any use of cigarettes or other tobacco/nicotine products within the past year (i.e., cigars, chewing tobacco, nicotine patch/gum, or other nicotine delivery system)						
Please answer the following questions only if you are applying for Level II 'Plus' coverage.							
14.	Have you in the past 5 years flown, or do you intend to fly, other than as a passenger?						
15.	Have you in the past 2 years, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot-air ballooning, ultra-light flying, mountain or rock climbing, motor vehicle racing, or scuba or sky diving?						
16.	Have you in the past 5 years traveled or resided, or do you intend to, outside the continental US for more than 4 consecutive weeks?						
17.	Have you ever been convicted of a misdemeanor (other than minor traffic violation) or a felony?						
18.	In the past 5 years, have you had your driver's license suspended or had 2 or more moving violations or accidents?						
19.	Have you been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution?						
20.	Have you been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?						
21.	Have you been advised to limit or cease the use of alcoholic beverages?						
22.	Has any proposed insured's immediate family member (parent, brother, or sister) had heart disease, diabetes, cancer, polycystic kidney disease or other familial disease at age 65 or younger? If yes, please provide relationship, disease or illness, whether living or deceased and current age or age at death.						

If any of the above questions are checked yes, please provide the details on the lines below. Give name of family member, nature of illness, number of attacks, duration, dates, and names and addresses of attending physicians. If needed, attach a separate sheet(s) of paper, signed and dated, with additional details. **NOTE:** After a review of your application and examination results, further explanation of medical information may be requested, to include the possibility of a new examination or medical records.

CERTIFICATION: By my signature below I do attest that the statements and answers above are complete and true.

(Date) _____ (Insured's Signature) _____ (Insured's SSN) _____ (Spouse's Signature, if applicable) _____