Life Assurance Company, Inc.

UNDERWRITING QUESTIONNAIRE FOR CREDIT INSURANCE

P.O. Box 20667 • Oklahoma City, Oklahoma 73156 • 405-810-1111 • 800-522-1314

In order to accept/retain the risk of this credit insurance, we need the following underwriting questionnaire completed and returned to our office within the next two weeks in the enclosed envelope.

Name of Insured____Date of Birth____________________Occupation_________________________

Height_______________Weight____________ Has your weight changed within the last year? YES___ NO___ Gained______lbs; Lost______lbs

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY: (Use back side for more space)				
1. Have you had or do you now have:	**YES**	**NO**	**DATES**	**For all "YES" answers, indicate name and address of doctor(s), type of treatment, and current condition.**
• Diabetes? (Last three readings, A1C, specify type and medication)				
• High Blood Pressure? (Last three readings)				
• Cardiovascular Disease? Coronary Artery Disease? Congestive Heart Failure? (Specify medication)				
• Cancer? Leukemia? Specify type, present condition & date of last treatment.				
• Lung or Respiratory Disorder? COPD?				
• Chronic Muscle Disease?				
• Stroke? Epilepsy?				
• Kidney Disease? Renal Failure? (Specify medication)				
• Liver Disease? Cirrhosis? (Specify type of medication)				
• Disorders of the Nervous System?				
• Medically treated or diagnosed for Back, Neck, Spine, Shoulder or Knee? Carpal Tunnel Syndrome? Fibromyalgia?				
• Drug or Alcohol Abuse?				
• Depression? Mental or Emotional Disorders?				
• Acquired Immune Deficiency Disorder (AIDS), the AIDS Related Complex (ARC) or Tested Positive for HIV?				
2. Are you now taking medication other than listed above? Specify type of Medication.				
3. Have you been confined in the last 5 years to a hospital or sanitarium or seen a doctor for any reason other than listed above? If yes, please give full details.				
4. Within the past twelve (12) months have you been disabled (unable to work) or received any disability benefits?				
5. Are you working less than 30 hours per week for wages or profit?				
6. Do you use Tobacco products? (Specify type and amount)				
7. Are you now or have you ever been in the Armed Forces?				

I hereby certify that the answers to the above questions are correct to the best of my knowledge and belief. This questionnaire is subject to final acceptance or rejection by the Company. If the insurance is not accepted by the Company the Debtor shall be notified within 40 days and all premiums paid will be refunded to the Debtor. I further understand there is no obligation on the Company's part to make any investigation or underwriting decisions until a claim has been filed and if the aforesaid representations are false and untrue the Company's liability shall be limited to the return of the premium paid for said coverage.

WARNING: "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

Date__________________________________ ____
Signature of Proposed Insured (Full Legal Name)

____
Address City or Town State Zip code

IMPORTANT! YOUR COVERAGE CAN BE DENIED IF ANY ANSWER TO THE ABOVE HEATLH QUESTONS IS INACCURATE, MISTAKEN, OR INCOMPLETE.