THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

# Supplemental Death Benefits Health Statement

(MEMBER)

Please complete all information. You must also complete the Application for Supplemental Death Benefits and the Beneficiary Designation form. The Board of Pensions reserves the right to deny enrollment or a claim if the information provided on the health statement does not meet the Board's underwriting criteria or is determined to be false or misleading.

| **Member information** *(must complete)* | |
|---|---|
| Name | Last 4 digits of SSN |
| Height: _____ feet _____ inches | Weight: _____ pounds |

**Answer all questions and subsections.**

1. In the three years immediately preceding this application, have you sought medical advice for, received treatment for, or been told that you have:

| | | |
|---|---|---|
| a) Cancer, leukemia, Hodgkin's disease, or other associated malignancies? | ☐ Yes | ☐ No |
| b) Heart disease, stroke, or other related cardiovascular diseases? | ☐ Yes | ☐ No |
| c) Alcoholism or a drug habit? | ☐ Yes | ☐ No |
| d) Any disease of the kidney? | ☐ Yes | ☐ No |
| e) Any disease of the lung? | ☐ Yes | ☐ No |
| f) Any disease of the liver? | ☐ Yes | ☐ No |
| g) Any neurological disorder *(such as seizures or epilepsy)*? | ☐ Yes | ☐ No |
| 2. Have you ever tested positive for HIV? | ☐ Yes | ☐ No |

**If you answered "yes" to any questions in 1 and 2 above, please answer these questions:**

What is your exact diagnosis?

When was this diagnosis first made?

What medications do you take regularly for this diagnosis?

What treatment plan(s), if any, have you tried or are you following?

Are there any contributing factors, such as smoking or high blood pressure?

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| | | |
|---|---|---|
| 3. In the past six months, except for kidney stones or gallbladder removal, hernia repair, or childbirth, have you:<br>a. been advised to have a surgical procedure but did not have it performed? If "yes," please explain the recommended surgical procedures and reasons for not having it performed: | ☐ Yes | ☐ No |
| b. been hospitalized or had a surgical procedure performed? If "yes," please explain:<br><br>Name and address of the hospital/facility:<br><br>Dates of confinement/procedure: | ☐ Yes | ☐ No |
| 4. Do you participate in any fitness or wellness programs? If "yes," at what frequency and duration do you participate? | ☐ Yes | ☐ No |

## Use and disclosure

I declare that to the best of my knowledge and belief, all information provided is complete and true concerning my past and present state of physical and mental health and my medical history. I understand that if my present state of health changes after the date this application is signed but before the effective date of coverage, I must submit an updated Health Statement to the Board of Pensions for consideration. If I fail to report a condition or to file any required updated Health Statement, I understand that the Board, upon investigation, may determine that:

a) had such original or updated Health Statement been filed, any non-guaranteed issue coverage would not have been approved. The Board will deny payment in the amount of the non-guaranteed issue coverage and will refund any dues paid for such coverage.

b) the cause of death is a pre-existing condition that should have been reported to the Board of Pensions on an original or updated Health Statement. Although coverage – initial or additional – would still have been issued, no payment will be made under such initial or additional coverage because death resulted from a pre-existing condition.

I agree that this document and all its contents shall form a part of my enrollment application for Supplemental Death Benefits. The information may be used to decide if I am eligible for coverage. It may also be sent to any individual or organization that performs service in connection with the coverage for which I have applied. I understand any material misstatement can result in denial of benefits. I understand that an authorized representative or I have the right to receive a copy of this application.

| Member's signature *(required)* | Date *(mm/dd/yyyy)* |
|---|---|

## Permission to obtain information

I hereby authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, consumer credit reporting agency, or employer (present or former), or any other similar person, institution, or organization to provide The Board of Pensions of the Presbyterian Church (U.S.A.) with any and all information, including personal health information and copies of records related to me. I authorize The Board of Pensions of the Presbyterian Church (U.S.A.) to access any medical or disability records on file or available to the Board for Benefits Plan claims purposes. The information requested may include all information available as to diagnosis and treatment with respect to any physical or mental condition.

| Member's signature *(required)* | Date *(mm/dd/yyyy)* |
|---|---|

**Complete and email this form to the Board of Pensions at memberservices@pensions.org.**
If you need assistance emailing this form, please contact the Board at 800-773-7752 (800-PRESPLAN).