ASSOCIATION_____

ADDRESS_____

CERTIFICATE #_____

APPLICANTS NAME _____

SSN_____OCCUPATION_____

ADDRESS_____
St/P.O. Box City ST Zip

Rel to App._____Sex_____DOB_____Age_____Amount_____Premium_____

The Applicants agrees to pay dues in advance as follows:

Monthly Dues_____, Quarterly Dues_____, Semi Annual Dues_____, Annual Dues____
Total_____

FAMILY PHYSICIAN_____

1. Have you ever experienced or been treated for: Chest pain, high blood pressure, or any heart trouble? Explain & give dates of treatment._____
2. Are you now or have you been on medication such as digitalis, blood pressure medicine, nitroglycerine or anticoagulants (blood thinner)etc?_____
3. Do you have diabetes? If so, please state your treatment and current medication, and if treatment is by diet, oral medication or insulin_____
4. Have you ever been treated for cancer or tumor? If yes, please give diagnosis, dates, and outcome. This question also applies to Leukemia._____
5. Do you suffer from or have you had emphysema, asthma or bronchitis? Also give dates, treatment and outcome._____
6. Have you ever experienced or been treated for any form of kidney disease? If yes, five diagnosis, dates of treatment and outcome._____
7. Have you ever been treated or been diagnosed for drug or alcohol abuse? If yes, give dates of treatment and outcome._____
8. Have you ever been paralyzed? Give severity and parts paralyzed._____
9. Have you been treated for or diagnosed as having AIDS or any other sexually transmitted disease_____
10. Have you ever had an application for life, accident or health insurance declined or such policy of insurance rated or modified, cancelled or renewal refused by any company or association. If so by whom._____
11. Give information regarding any other treatment or illness or surgery in the past five years. Omit colds, routine check ups and other minor aliments._____
12. It is understood by signature that if death occurs within 24 months of the date of this certificate from any reason other than an accident, the claim will be reviewed by the Arkansas Burial Association Board. If there has been a material misrepresentation prior to date of issue of this certificate, or if the death is due to suicide, the certificate is ruled invalid and a refund of all dues paid will be made.

APPLICANTS SIGNATURE_____DATE_____

AGENT_____

RULE 42. MEDICAL GUIDELINES

The following listed guidelines shall be used in issuing new business:

MEDICAL GUIDELINES TO DETERMINE IF A CERTIFICATE SHOULD BE WRITTEN OR DECLINED

MEDICAL CONDITION		INSURE
Heart Disease	Last Occurrence 5 years or longer	**X to $1,000**
X	Last Occurrence less than 5 years	
Stroke	More than 3 years ago	**X to $1,000**
X	Less than 3 years ago	
Cancer	If remission is 5 years or longer	**X to $1,000**
X	If active or in remission less than 5 years	
High Blood Pressure	Under control, taking medication and bottom reading less than 90	**X to $1,000**
X	Not Controlled	
Kidney Disease	If they have any occurrence do not write	
X		
Emphysema	If they are Bedfast	
X		
	If controlled by medication	**X to $1,000**
Diabetes	If Controlled	**X**
	If Not Controlled	
X		
Excessive Use of Alcohol or Drugs	If answer is Yes	
X		
Paralyzed	If paralyzed from waist down or greater	
X		
	If otherwise	**X**