Disability Insurance Eligibility Questions

1) AIDS History

In the last 5 years, has a member of the medical profession diagnosed or treated you for Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for antigens or antibodies to an AIDS virus?

- ☐ Yes ☐ No

If **Yes**, list details in Section 7.

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2) Blood Pressure History

In the last 1 year, have you had a **systolic** blood pressure reading **higher than 150** more than once **or** a **diastolic** reading **higher than 100** more than once **confirmed by a medical professional**?

- ☐ Yes ☐ No

If **Yes**, check all that apply above **and** add details in Section 7.

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3) Major Medical Condition History

In the last 2 years, has a member of the medical profession diagnosed or treated you for any of the following?

- ☐ Cancer (except basal cell carcinoma)
- ☐ Central Nervous System disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
- ☐ Chronic Fatigue Syndrome
- ☐ Counseling for alcohol or drug abuse

- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart Disease/Disorder
- ☐ Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- ☐ Liver Disease/Disorder
- ☐ Lung Disease/Disorder
- ☐ Lupus
- ☐ Optic Neuritis
- ☐ Pancreas Disease
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Rheumatoid Arthritis
- ☐ Stroke (including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation)

If **Yes**, check all that apply above **and** add details in Section 7.

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4) Back/Asthma History

In the last 2 years, have you had any disease of, been impaired by, or received treatment from a medical professional for any of the following (other than minor illness)?

- ☐ Any disorder of the back or neck
- ☐ Asthma

If **Yes**, check all that apply above **and** add details in Section 7.

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5) Pregnant/Fertility Treatment (if applicable) — current status

Are you **currently pregnant** or **undergoing fertility treatment**?

☐ Yes ☐ No

If **Yes**, check all that apply above **and** add details in Section 7.

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6) Height and Weight

- **Height: _____** ft **_____** in
- **Weight: _____** lbs

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7) Required Health History (complete only if any “Yes” above)

Provide health history for any **Yes** answers to Questions 1–5. Include **physician/clinic name**, **address**, **phone**, **condition/diagnosis**, **dates of onset and last treatment**, **medications**, **degree of recovery**.