

Please retain copy for your records. Please Print. Press firmly with ball point pen.

TO BE COMPLETED BY PERSON TO BE INSURED	Employer's Name	Group Policy No.	Social Security No.	Occupation																																																																																																																					
	Employee's Name and Address																																																																																																																								
Check here if you are applying as a late entrant for medical coverage. <input type="checkbox"/> Check here if you are applying for excess life. <input type="checkbox"/>																																																																																																																									
Dependent's Name if this Statement is for Dependent Insurance (For each dep. complete one health statement)																																																																																																																									
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Date of Birth	Place of Birth	Height (in shoes) ft. in.		Weight (with clothes) lbs.																																																																																																																					
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AUTHORIZATION

Please give to the **Alta Health & Life Insurance Company** all information it may request regarding the medical history and physical condition of _____
(Insert Name of Person to be Examined)

A photostatic copy of the authorization shall be considered as valid as the original.
 Thank you for your courtesy.

 Signature of Person Examined if Over Age 16,
 Otherwise Signature of Employee

Address _____