

STATEMENT OF HEALTH

WHEN REQUESTING A WAIVER OF THE TWO-YEAR FILING PERIOD, THIS FORM MUST ACCOMPANY YOUR ELECTION. IN ADDITION, THE PENSION PLAN (THE “PLAN”) REQUIRES SUBMISSION OF A PHYSICIAN-COMPLETED HISTORY AND PHYSICAL (H&P) DATED WITHIN THE PRECEDING 12 MONTHS.

SECTION 1

IDN OR LAST 4 SSN: _____

NAME OF PARTICIPANT: _____

ADDRESS: _____ DOB: _____

TELEPHONE NO.: _____

EXPECTED RETIREMENT DATE: _____

SECTION 2

ALL QUESTIONS MUST BE ANSWERED “YES” OR “NO”. IF YOU ANSWER “YES” TO ANY QUESTION, GIVE DETAILS AT THE END OF THIS SECTION.

1. HAS ANY APPLICATION ON YOUR LIFE FOR LIFE, ACCIDENT, OR SICKNESS INSURANCE BEEN DECLINED, POSTPONED, OR MODIFIED? YES NO
2. HAS ANY CLAIM EVER BEEN MADE OR HAVE ANY PAYMENTS OR BENEFITS BEEN RECEIVED FOR YOUR SICKNESS OR INJURY? YES NO
3. HAVE YOU EVER HAD:
 - a. ANY SURGICAL OPERATION? YES NO
 - b. SURGERY ADVISED NOT PERFORMED? YES NO
 - c. X-RAY OR ELECTROCARDIOGRAM? YES NO
4. HAVE YOU EVER CONSULTED, OR BEEN TREATED BY A PHYSICIAN OR PRACTITIONER FOR ANY OF THE FOLLOWING?
 - a. BRAIN OR NERVE DISEASE, DIZZINESS, EPILEPSY, SEVERE HEADACHE. UNCONSCIOUSNESS, PARALYSIS, NERVOUS BREAKDOWN, OR OTHER NERVOUS OR MENTAL DISORDER? YES NO
 - b. LUNG DISEASE, PLEURISY, CHRONIC COUGH, OR ASTHMA YES NO
 - c. BLOOD VESSEL DISEASE OR VARICOSE VEINS YES NO
 - d. HEART DISEASE, PAIN IN CHEST, CORONARY ARTERY DISEASE, ANGINA PECTORIS, OR RHEUMATIC FEVER YES NO

