GROUP QUESTIONNAIRE

This form can be duplicated

(1) Has any employee/dependent been treated for an illness (physical or mental), had more than $5000 of medical expenses, or been hospitalized or had surgery in the past twelve months? **YES NO**

(2) Has anyone been advised to have a surgery or medical treatment? **YES NO**

(3) Does anyone anticipate hospitalization for any reason? **YES NO**

(4) Are any employees or dependents pregnant? **YES NO**

PLEASE PROVIDE DETAILS TO ANY QUESTION ANSWERED "YES"

Employee or dependent	Age	Nature of Condition	Treatment Dates	Amount of Claim	Prognosis/Current Treatment

COMPANY DEMOGRAFICS: (All fields must be complete)

Name of Business:_____ **Nature of Business**_____

Address:_____**City:**_____ **TX Zip**_____

Contact Person:_____ **Phone:**_____ **SIC Code**_____

OPTIONAL BENEFITS:

_____ **Dental** _____ **Accident** _____ **Cancer** _____ **Vision** _____ **Maternity** _____ **Short Term Disability**

_____ **Long Term Disability Low Cost Life** _____**25,000** _____**50,000** _____**75,000 Other**_____

GROUP CENSUS - PROVIDE EMPLOYEE INFORMATION BELOW

Employee	Sex M/F	Employee Birthdate or Age	Coverage Type EE, ES, EC, EF* See key below	Zip Code	Spouse Birthdate or Age	# of Children to be covered	Salary if disability wanted

***Key: Coverage Type: EE = employee ES = employee/spouse EC = employee/child EF = employee/family**

PLEASE FAX THIS FORM TO MASTERKEY FINANCIAL SERVICES: (817) 731-2058

GROUP CENSUS - PROVIDE EMPLOYEE INFORMATION BELOW

Employee	Sex M/F	Employee Birthdate or Age	Coverage Type EE, ES, EC, EF* See key below	Zip Code	Spouse Birthdate or Age	# of children to be covered	Salary if disability wanted

*Key: Coverage Type: EE = employee ES = employee/spouse EC = employee/child EF = employee/family

PLEASE FAX THIS FORM TO MASTERKEY FINANCIAL SERVICES: (817) 731-2058