STATEMENT OF GOOD HEALTH

BAF Med**Safe** Secure Care • BAF Med**Safe** Critical Care

Policy Number	
Insured	
Date of Birth	
ID Type & Number	
Policyholder's Name	

With my signature below, I hereby certify, to the best of my knowledge, that since the date of the original application, **NO INSURED PROPOSED FOR COVERAGE** under this policy has been diagnosed, has been recommended to receive, or received treatment, or has shown symptoms of any physical or mental disorders, except as described in the application.

If the above statement is incorrect, please indicated the name of the Insured whose condition has change, the diagnosis, the clinical or surgical treatment received or recommended, and the results, as well as the name, and telephone number of all physicians, clinics, and hospitals involved in said Insured's treatment.

Insured's Name	
Condition	
Diagnosis	

Clinical or surgical treatment ☐ Received ☐ Recommended

Results	
Name of Physician	
Address	
Telephone	
Name of Hospital	
Telephone	

Is any female proposed for coverage under this policy currently pregnant? ☐ Yes ☐ No

Insured's Name		DOB	

It is understood that this "Statement of Good Health" and any other document submitted with the application shall be the basis of any coverage provided. No coverage shall take effect unless and until the application is approved by the Insurer.

Insured's Signature *(if age 18 or older)*		Date	
Policyholder's Signature *(if different that the insured)*		Date	
Agent's Signature		Date	