

# SUPPLEMENT TO APPLICATION FOR INSURANCE

This form is to be completed in all cases at the time of application, as a supplement to the Application for Insurance - Part 2 or Medical Part 2.

1. Proposed Insured (Please print)

**Yes No**

1. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome?
2. Have you received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome?

**Details of Yes answers:** Include diagnoses, dates, names and addresses of all physicians and medical facilities below:

If either question has been answered Yes, I **AUTHORIZE** any physician or medical practitioner who has observed me for diagnoses or treatment, to give to Crown Life Insurance Company full particulars including any prior medical history, to the extent permitted by law. I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action.

To the best of my knowledge and belief, the answers and statements contained in this supplement are full, complete and true. I understand they will become part of the Application for Insurance.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ year

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Signature of Proposed Insured

X

Signature of Witness

X

**If preferred, you may complete this supplement in private and mail it directly to: The Chief Medical Director, Crown Life Insurance Company, Serviced At: P.O. Box 1927, Buffalo, NY 14240-1927**