ATG Resources, Inc. Tel: 908-256-9423

Medical Questionnaire

PRIMARY PROPOSED INSURED **Date:** _____

1. Last Name _____
2. First Name _____
3. In which state do you maintain your primary residence? _____
4. Do you maintain a residence in any other state? Y ❒ N ❒ If yes, which one(s)?

   _____
5. Are you a citizen of the United States? Y ❒ N ❒ If not, of which country are you a citizen?

   _____

   Do you have a green card? Y ❒ N ❒
6. Your occupation: _____
7. Annual Income: _____
8. In which state is your employer located? _____

Health History

1. Gender _____ 2. Date of Birth _____
3. Height _____ 4. Weight _____
5. Have you lost or gained more than 10 lbs in the last year? Y ❒ N ❒

   If so, what caused the weight change? _____
6. Do you smoke any form of tobacco (cigarettes, cigars or pipes)? Y ❒ N ❒
   a. If so, what do you smoke and how often do you smoke it? _____
   b. If not, do you chew tobacco? Y ❒ N ❒
   c. Did you ever smoke? Y ❒ N ❒ If so, date you last smoked? _____
   d. Do you wear a nicotine patch? Y ❒ N ❒
7. Have you ever used marijuana, heroin, cocaine, or any other drugs? Y ❒ N ❒

   If so, when was the last time? _____
8. Do you drink alcohol? Y ❒ N ❒ If so, what do you drink, how much of it do you drink, and how often do you drink it? _____

9. Have you or anyone in your immediate family - just your parents, brothers and sisters - had cancer, diabetes or heart disease?

If so, please provide the following information for each person: (use a separate sheet of paper for more room)

Person A	Person B
Relation to You: _____	Relation to You: _____
Type of Illness: _____	Type of Illness: _____
Age of Onset: _____ Date of Onset: _____	Age of Onset: _____ Date of Onset: _____
Age, if Living: _____ or Age at Death: _____	Age, if Living: _____ or Age at Death: _____
Stage (if Cancer): _____	Stage (if Cancer): _____
Treatment Type: _____	Treatment Type: _____

Additional Health History

Have you ever been diagnosed or treated for (yes/no):

a. Alcohol Abuse	Y ❒ N ❒	j. Heart Disease	Y ❒ N ❒
b. Asthma	Y ❒ N ❒	k. Hepatitis	Y ❒ N ❒
c. Bipolar Disorder	Y ❒ N ❒	l. High Blood Pressure	Y ❒ N ❒
d. Cancer	Y ❒ N ❒	m. High Cholesterol	Y ❒ N ❒
e. Crohns Disease/Colitis	Y ❒ N ❒	n. HIV	Y ❒ N ❒
f. Depression	Y ❒ N ❒	o. Kidney Disease	Y ❒ N ❒
g. Diabetes	Y ❒ N ❒	p. Respiratory Disease	Y ❒ N ❒
h. Drug abuse	Y ❒ N ❒	q. Sleep apnea	Y ❒ N ❒
i. Epilepsy/Seizure Disorder	Y ❒ N ❒		

Please explain any yes answers:

_____

_____

_____

_____

Why have you visited a doctor or hospital in the last 10 years? _____

_____

Have you ever been declined or rated on a prior application for life insurance? Y ❒ N ❒

If so, what was the reason?

_____

Medication

Are you current taking any prescription medication? If so, please list below:

Name _____ Dosage _____ Reason :_____

Name _____ Dosage _____ Reason :_____

Name _____ Dosage _____ Reason :_____

Additional Information

1. Driver's License Information: License # _____

   License State: _____ Issue Date: _____ Expiration Date: _____
2. How many moving violations on your driver's license have you had in the last 10 years?

   _____
3. Have you ever been charged or convicted of a felony? Y ❒ N ❒
4. Do you participate in scuba diving, auto racing, piloting an aircraft, or mountain climbing? Y ❒ N ❒
5. Do you ever travel outside of the United States for business or pleasure? Y ❒ N ❒

   If so, where do you go? _____
6. Is there any other information you think we should know? Y ❒ N ❒

   If yes, please explain below or attach another page.

   _____

   _____

   _____

   _____

Beneficiary/Insurance Information

1. Who would be the beneficiary of your policy? _____
2. Will the benefit be used to replace your income? Y ❒ N ❒
3. Will the benefit also be used to pay off a mortgage or other debt? ? Y ❒ N ❒
4. How much insurance do you need to have? _____
5. For how long do you want to have this protection in force (i.e., 20 years, 30 years, the rest of my life)?

   _____

_____ _____

Signature of Proposed Insured Date