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# DECLARATION OF INSURABILITY

FOR OFFICE USE ONLY	
APPROVED	<input type="checkbox"/>
HIGH RISK	<input type="checkbox"/>
DECLINE	<input type="checkbox"/>
EFFECTIVE	_____
INITIALS	_____

**IMPORTANT NOTE: ANY INSURANCE COVERAGE RESULTING FROM THIS DECLARATION OF INSURABILITY WILL BE EFFECTIVE THE DATE DESERET MUTUAL DETERMINES THE EVIDENCE TO BE SATISFACTORY, SUBJECT TO THE PRE-EXISTING CONDITIONS PROVISION.**

1. NAME OF EMPLOYEE \_\_\_\_\_ DESERET MUTUAL ID NO. \_\_\_\_\_  
 ADDRESS OF EMPLOYEE \_\_\_\_\_ EMPLOYMENT DATE \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ MO. DAY YEAR

2.

LIST BELOW YOURSELF AND YOUR IMMEDIATE FAMILY ONLY (ONLY ONE FORM PER FAMILY IS REQUIRED)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	AGE	HEIGHT (Ft., In.)	WEIGHT (Lbs.)	WEIGHT 1 YEAR AGO	OCCUPATION
EMPLOYEE (FULL NAME)	SELF						
DEPENDENTS (FULL NAME)	SPOUSE						

- IS EACH PERSON LISTED ABOVE NOW IN GOOD HEALTH? \_\_\_\_\_ IF NOT, GIVE NAME(S) AND DETAILS. \_\_\_\_\_
- DO YOU KNOW OF ANY EXISTING AILMENT, DISEASE, OR OTHER CONDITION WHICH IS LIKELY TO LEAD TO HOSPITALIZATION, SURGERY, OR OTHER MEDICAL EXPENSE (INCLUDING PREGNANCY) FOR ANY PERSON LISTED ABOVE? \_\_\_\_\_ IF SO, GIVE NAME(S) AND DETAILS. \_\_\_\_\_
- HAS ANY COMPANY OR ASSOCIATION EVER DECLINED TO GRANT INSURANCE ON ANY PERSON LISTED ABOVE OR OFFERED A MODIFIED POLICY? \_\_\_\_\_ IF SO, GIVE REASONS, NAME(S), DATES, AND NAME OF THE COMPANY. \_\_\_\_\_
- IS ANY PERSON LISTED ABOVE TAKING MEDICATION OF ANY TYPE? \_\_\_\_\_ IF SO, GIVE REASONS, NAME(S) AND DETAILS. \_\_\_\_\_
- HAS ANY PERSON LISTED ABOVE EVER RECEIVED DISABILITY COMPENSATION? \_\_\_\_\_ IF SO, GIVE REASONS, NAME(S) AND DETAILS. \_\_\_\_\_
- HAS ANY PERSON LISTED ABOVE EVER USED LSD, SPEED (AMPHETAMINES), DOWNERS (BARBITURATES), MARIJUANA, HASHISH, OR ANY OTHER HARMFUL DRUG? \_\_\_\_\_ IF SO, GIVE NAME(S) AND STATE THE NAME(S) OF THE DRUG. \_\_\_\_\_
- HAS ANY PERSON LISTED ABOVE BEEN TREATED FOR OR BEEN DIAGNOSED AS HAVING ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC) OR OTHER IMMUNE DEFICIENCY DISORDERS? \_\_\_\_\_ IF SO, GIVE NAME(S) AND DETAILS. \_\_\_\_\_

