MEBA MEDICAL & BENEFITS PLAN
MEBA PENSION TRUST
MEBA TRAINING PLAN
MEBA VACATION PLAN

1007 EASTERN AVENUE, BALTIMORE, MARYLAND 21202-4345 • (410) 547-9111

STATEMENT OF HEALTH

This form must accompany your Election if you are requesting a waiver of the two-year filing period.

Section 1

Name of Participant: ______________________ SS#: ______________

Address: ______________________ ______________ ______ ______________
Number and Street | City | State | Zip

Date of Birth: ______________ Expected Retirement Date: ______________

Telephone No.: ______________ Cell Phone No.: ______________

Section 2

If you have had an examination at a MEBA Diagnostic Center within the past 12 months, indicate the date and location of your last examination and complete the attached authorization for release of health information.

DATE OF LATEST DIAGNOSTIC CENTER EXAMINATION:

DIAGNOSTIC CENTER LOCATION AT WHICH YOU WERE EXAMINED:

______________ ______________ ______________ ______
Month | Year | City | State

Section 3

All questions must be answered "Yes" or "No". If you answer "Yes" to any question, give details at the end of this section.

1. Has any application on your life for life, accident or sickness insurance been declined, postponed or modified? ○ Yes ○ No

2. Has any claim ever been made or have any payments or benefits been received for your sickness or injury? ○ Yes ○ No

3. Have you ever had:
   a. Any surgical operation? ○ Yes ○ No
   b. Surgery advised but not performed? ○ Yes ○ No
   c. X-Ray or Electrocardiogram ○ Yes ○ No

4. Have you ever had, consulted or been treated by a physician or practitioner for any of the following? (Answer "Yes" or "No" to each):

Condition	Answer	Condition	Answer
Brain or Nerve Disease, Dizziness, Epilepsy, Severe Headache, Unconsciousness, Paralysis, Nervous Breakdown or other Nervous or Mental Disorder	○ Yes ○ No	Indigestion, Ulcers, Colitis, Diarrhea, Rectal Disease, Hemorrhoids, Hernia, Gall Bladder, or Liver Disease or Jaundice	○ Yes ○ No
Lung Disease, Pleurisy, Chronic Cough or Asthma	○ Yes ○ No	Albumin, Sugar, Blood or Pus in Urine	○ Yes ○ No
Blood Vessel Disease or Varicose Veins	○ Yes ○ No	Arthritis, Allergy, Skin Disease or Syphilis	○ Yes ○ No
Heart Disease, Pain in Chest, Coronary Artery Disease, Angina Pectoris or Rheumatic Fever	○ Yes ○ No	Kidney, Bladder or Prostate Disease, Colic, Stone or other Diseases of the Genito-Urinary Organs.	○ Yes ○ No
Increased or Abnormal Blood Pressure	○ Yes ○ No	Cancer, Tumor, Thyroid Disease or Diabetes	○ Yes ○ No
Eye or Ear or Speech Impairment	○ Yes ○ No	Back Impairment, Amputation or Body Deformity	○ Yes ○ No

Give full details of Questions 1 through 4 answered "Yes". Specify dates, duration, severity, results, the names and addresses of any physicians, hospitals, etc. Indicate Number of Question to which details apply.

I hereby certify that all the above statements are true and correct to the best of my knowledge and belief.

Participant's Signature: ______________________ Date: ______________