

# Amendment to Original Application



Please return this completed form to your personnel, payroll, insurance or benefits office. The non-tobacco rate will be effective the first of the month following the signature date.

Group Name <b>Washington State Health Care Authority</b>		
Group Number <b>12373-1</b>	Account Number	Certificate Number
Applicant Name - Please Print ( <i>Last, First, M.I.</i> )		
Birth Date	Social Security Number	

For purposes of applying for the NON-TOBACCO USER RATES, I hereby amend my application for insurance dated \_\_\_\_\_ to include my answer to the following questions, agreeing that this amendment is to be made a part of my application and considered as a basis of the contract for insurance.

1. Have you smoked cigarettes in the last 12 months? \_\_\_\_\_  
\_\_\_\_\_
2. Have you used tobacco in any other form in the last 12 months? \_\_\_\_\_  
If so, give details: \_\_\_\_\_  
\_\_\_\_\_

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, in the year, \_\_\_\_\_

\_\_\_\_\_  
Signature of Life Proposed

\_\_\_\_\_  
Signature of Owner (if other than Life Proposed)