BACK PAIN QUESTIONNAIRE

Name of Proposed Insured: ____________________________
Policy No: ____________________________

1. Date of onset of back pain? __________________________________

2. How often does pain occur? __________________________________

3. Location(s) of pain? __________________________________

   Radiation to: __________________________________

4. What will cause pain to start? __________________________________

5. Name(s) of doctor(s) consulted and dates:

<table>
<thead>
<tr>
<th>Name of Doctor(s)</th>
<th>Address of Doctor(s)</th>
<th>Date</th>
<th>Diagnosis</th>
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6. Any treatment? □ Yes □ No
   If "Yes" give details. __________________________________

7. Are you limited in any way due to pain? □ Yes □ No
   If "Yes" give details. __________________________________
8. Have you missed any time from work because of back pain?  □ Yes  □ No

If "Yes" give details. ________________________________________________________________
________________________________
________________________________
________________________________
________________________________

I hereby agree that this supplement shall form a part of the application and of the policy issued thereunder, if any, and that it shall be binding on any person or persons who shall have or claim any interest under such policy. I have carefully read the above questions, statements, and answers and all such statements and answers are correctly recorded and are true as written above.

Dated this ______________________________day of __________________________, 20____________

________________________________               __________________________
Advisor/Witness               Signature of Proposed Insured               Applicant (if other than Proposed Insured)

UND70017 – February 2015