AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094

Tumor/Cyst Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: ______________________________ ID/SSN: ____________________

Form No.__________

Name of person treated: ______________________________ Relationship to applicant: ____________

1. Diagnosis (type) of tumor/cyst:______________________________

2. Date of onset or date of diagnosis:______________________________

3. Was your tumor/cyst diagnosed as malignant or benign? ☐ Yes ☐ No If yes, please explain:____________________

   What was the size of the tumor/cyst:______________________________

   Where was the location of the tumor/cyst:______________________________

   Have there been metastasis or spread to any other location(s)? ☐ Yes ☐ No If yes, please provide details: __________

   Has there been a recurrence or relapse? ☐ Yes ☐ No If yes, please give details:____________________

4. Did you receive medication for the tumor/cyst?☐ Yes ☐ No If yes, please provide name of medication, dosage, frequency and dates medication was taken or if it is still being taken: ____________________

   Did you receive radiation or chemotherapy for your tumor/cyst? ☐ Yes ☐ No If yes, please give details (include type of therapy, date therapy started and ended) ____________________

5. Did you have surgery or been advised to have surgery to remove the tumor/cyst? ☐ Yes ☐ No If yes, please give details (date of surgery, type of surgery, date of discharge):____________________

6. Have you been released from all treatment for your tumor/cyst? ☐ Yes ☐ No If no, please explain details of current treatment: ____________________

7. Are further studies or future operations for the tumor/cyst anticipated? ☐ Yes ☐ No If yes, when?__________

8. Name and address of treating physician: ____________________

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

______________________________ ____________

Signature of person treated (or parent/guardian if under 18) Date