

APPLICATION FOR LIFE INSURANCE - PART 2

DECLARATIONS MADE TO MEDICAL EXAMINER

NOTE: Positive identification should be made by medical examiner.

SECTION 1. GENERAL INFORMATION

Is the Proposed Insured able to read and understand all of the questions on this Application? Yes No

If No, indicate how this Application is being translated:

Translator (Translation cannot be done by the Proposed Owner or the Beneficiary)

Translator's Name (first) (mi) (last) (suffix)

AT & T Language Line (Operator #)

SECTION 2. PROPOSED INSURED

Proposed Insured's Name

(first) (mi) (last) (suffix)

Address City/Town State Zip

Birth Date Social Security Number

SECTION 3. UNDERWRITING QUESTIONS. (To be asked of the Proposed Insured) The following disclosure applies to all Underwriting questions in Section 3.

The Proposed Insured does not have to disclose the performance of or the results of a test to determine the presence of the Human Immunodeficiency Virus (HIV) antibody or the presence of a bloodborne pathogen that was administered: (1) to an offender or a crime victim who was exposed to or had contact with an offender's bodily fluids during the commission of a crime that was reported to law enforcement officials; (2) to a patient who received the services of an emergency medical services person at a hospital or medical care facility; (3) to an emergency medical services person who was tested as a result of performing emergency medical services; (4) to an inmate while incarcerated; (5) to a corrections employee while performing his/her duties at a state or local correctional agency; or (6) to an employee of a secure treatment facility while performing his/her duties at such facility; or (7) to a patient while being treated at or committed to a secure treatment facility. Emergency medical services person means an individual employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties; an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; an individual who renders emergency medical care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good Samaritan; any individual who, in the process of executing a citizen's arrest may have experienced significant exposure to a source individual. Source individual means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of bloodborne pathogen exposure to an emergency medical services person. This includes but is not limited to, a victim of an accident, injury or illness of a deceased person. Significant exposure means contact likely to transmit a bloodborne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at a time an evaluation takes place that includes: 1. Percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact on intact skin; and 2. Contact in a manner that may transmit a bloodborne pathogen, with blood, tissue, or potentially infectious body fluids. Inmate means an individual who is in the custody or under the jurisdiction of the commissioner of corrections or a local correctional authority and is confined in a state or local correctional facility either before or after conviction. Corrections employee means an employee of a state or local correctional agency. Secure treatment facility means the Minnesota security hospital or the Minnesota sexual psychopathic personality treatment center. Employee of a secure treatment facility means an employee of the Minnesota security hospital or the Minnesota sexual psychopathic personality treatment center. Patient means any person who is receiving treatment from or committed to a secure treatment facility.

1. Do you have a primary care physician/health care facility? Yes No If Yes, complete the following:

Primary care physician/health care facility's name

Address City/Town State Zip

Telephone No. Date of and reason for last contact

USE ONLY IN MINNESOTA

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2. Have you used any nicotine products during the past 36 months? If Yes, give product (cigarettes, cigars, etc.) and date last used. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any immunological disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past five years, have you: | | |
| a. used alcohol or drugs daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. been told to discontinue the use of alcohol or drugs, been treated, counseled or joined an organization because of such use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been diagnosed with or been treated for: (Indicate applicable conditions) | | |
| a. stroke; heart murmur; heart attack; high blood pressure; any disorder of the heart, blood vessels, or blood; anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. cancer; tumor; diabetes; seizures; paralysis; or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. loss of vision; loss of hearing; or any disorder of the eyes, ears, nose, or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. mental, emotional or neurological disorder or any other disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. any disorder of the respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. any stomach, gallbladder, intestinal or liver disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. any disorder of the bladder, prostate, kidneys; sugar, protein, or blood in urine; any disorder of the breast or reproductive organs; complications of pregnancy; sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. thyroid or hormone disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. deformity, lameness, amputation or any disorder of the muscles, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past five years have you had, been told you have or been treated for: (Indicate applicable conditions) | | |
| a. chest pain; irregular heart beat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. persistent skin lesions; or disorder of the lymph glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. blurred vision; difficulty hearing; hoarseness? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. dizziness; fainting; headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. shortness of breath; difficulty breathing; persistent cough; coughing up blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. intestinal bleeding, chronic diarrhea, recurrent indigestion, jaundice, chronic abdominal pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. frequent urination; difficulty urinating? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. chronic joint pain; swelling; stiffness; or imbalance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. In the past five years have you: | | |
| a. consulted any physician/health care facility, been hospitalized, been advised to receive treatment, or take medication or are you now receiving treatment, taking medication or have you been advised to have or contemplated surgery for any reason not previously explained? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. had an electrocardiogram, x-ray, blood study, urinalysis or other diagnostic study? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. had an unexplained or unintentional weight loss or gain of more than ten pounds? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Loss of pounds in months <input type="checkbox"/> Gain of pounds in months | | |
| 8. To the best of your knowledge, is there a history in parent(s) or sibling(s) of diabetes; mental, emotional or neurological disorder; heart, kidney, or circulatory disorder; cancer; or death before age 60? | <input type="checkbox"/> | <input type="checkbox"/> |

| Family History | Age if Living | Cause of Death | Age at Death |
|----------------|---------------|----------------|--------------|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| # Living | | | |
| # Dead | | | |

GIVE DETAILS BELOW FOR ANY YES ANSWERS TO QUESTIONS 1. - 7. If additional space is needed, use and attach a plain white sheet of paper. Include Application/Policy # and Proposed Insured's name on all additional sheets.

Question # Details or Reason (Give date of diagnosis or onset; medications; surgeries; hospitalizations; physician/health care facility's name, address, telephone # and reason for last contact)

I hereby declare that all the statements and answers to the questions on this Application are true and complete to the best of my knowledge and belief and I agree that they will form a part of the contract of insurance applied for.

A person who submits an Application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

State where signed _____ Date _____

Proposed Insured's Signature _____ Date _____

Translator's Signature _____ Date _____

Medical Examiner's Signature as Witness _____

