

Print full name of Proposed Insured _____ Date of Birth (Month/Day/Year) _____

1. Name & address of your doctor _____
Date last seen _____ Reason & Results _____

2. a. Do you use tobacco or nicotine products? Never Current Past - date last used _____

b. If current or past use, type/amount per day? Cigarettes _____ _____ Pipe/Cigar Chew Patch/gum

3. a. In the last 5 years, have you consumed alcohol?
 Never Current Past - date last used/reason quit _____

b. If current or past use, type/amount per week? Beer/Wine _____ Other _____

4. a. List weight change in last year _____ Gain Loss b. Reason _____

5. a. Has any parent or sibling died before age 60? Yes No If yes, ages at death _____

b. Relationship(s) _____ Cause(s) of death _____

6. Within the past 10 years have you been treated for or diagnosed as having:

	No	Yes
a. High blood pressure, chest pain, heart attack, or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma, bronchitis, emphysema, or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
c. Seizures, stroke, headaches; or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
d. Ulcer, colitis, cirrhosis, irritable bowel syndrome, hepatitis, or any other disease or disorder of the liver, gallbladder, pancreas, or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
e. Protein, sugar, or blood in the urine; or any other disease or disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes, thyroid disorder, or any other glandular disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. Cancer, tumor, cyst, or other growth (benign or malignant)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Back or neck pain, spinal strain or sprain, sciatica, arthritis, carpal tunnel syndrome, or any disc, bone, joint or muscle disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Chronic Fatigue Syndrome, Epstein Barr, Lyme's disease or any chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
j. Depression, stress, anxiety, or any other psychological or emotional disorder or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
k. Disease or disorder of the genitals or reproductive system, including the prostate, uterus, ovaries or breasts; or any sexually transmitted disease or pregnancy complications?	<input type="checkbox"/>	<input type="checkbox"/>
l. Disease or disorder of the skin, eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "yes" answers. List question number. Give dates, duration, treatment and doctors' names and addresses:

7. During the past 10 years have you:

a. been treated for or diagnosed as having any illness, injury or health condition not already indicated above; had or been recommended to have any treatment, hospitalization, surgery, medical test or medication?	<input type="checkbox"/>	<input type="checkbox"/>
b. Seen a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been medically advised to limit or discontinue the use of alcohol or drugs; sought or received treatment, counseling or participated in a group for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you ever had any test which indicated you have been infected with the HIV (AIDS) virus? No Yes

Medical Questionnaire, continued (if additional space needed, attach a separate page that is completed, witnessed and signed)

9. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Details of "yes" answers:
10. Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Date _____	Signed at (City, State) _____	Witness/Title _____	Signature of Proposed Insured X
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MEDICAL EXAMINER'S REPORT

<p>11 a. Height (In Shoes) feet _____ in. _____; or cm _____</p> <p>b. Weight (Clothed) pounds _____; or kg _____</p> <p>c. Did you weigh? <input type="checkbox"/> No <input type="checkbox"/> Yes Did you measure? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>d. Is appearance unhealthy or older than stated age? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>e. Chest (Full Inspiration) in./cm. _____</p> <p>Chest (Forced Expiration) in./cm. _____</p> <p>Abdomen, at Umbilicus in./cm. _____</p>																	
<p>12. Blood Pressure in sitting position prior to exercise:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:35%;">First Reading</td> <td style="width:50%;">Two additional readings if first greater than 135/85</td> </tr> <tr> <td>Systolic</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Diastolic</td> <td>_____</td> <td>_____</td> </tr> </table>		First Reading	Two additional readings if first greater than 135/85	Systolic	_____	_____	Diastolic	_____	_____	<p>13. Pulse:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">Rate</td> <td style="width:20%;">At Rest</td> <td style="width:10%;">After Exercise</td> <td style="width:10%;">3 Minutes Later</td> </tr> <tr> <td>Irregularities per min.</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Rate	At Rest	After Exercise	3 Minutes Later	Irregularities per min.	_____	_____	_____
	First Reading	Two additional readings if first greater than 135/85																
Systolic	_____	_____																
Diastolic	_____	_____																
Rate	At Rest	After Exercise	3 Minutes Later															
Irregularities per min.	_____	_____	_____															
<p>14. Heart: is there any:</p> <p>Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes Dyspnea <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Murmur(s) <input type="checkbox"/> No <input type="checkbox"/> Yes Edema <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>(describe below)</p> <p>Location _____</p> <p><input type="checkbox"/> Constant Indicate:</p> <p><input type="checkbox"/> Inconstant</p> <p><input type="checkbox"/> Transmitted Apex by X</p> <p><input type="checkbox"/> Localized</p> <p><input type="checkbox"/> Systolic Murmur area by ○</p> <p><input type="checkbox"/> Presystolic Point of greatest intensity by ○</p> <p><input type="checkbox"/> Diastolic</p> <p><input type="checkbox"/> Soft (Gr. 1-2)</p> <p><input type="checkbox"/> Mod. (Gr. 3-4)</p> <p><input type="checkbox"/> Loud (Gr. 5-6) Transmission by →</p> <p>After exercise:</p> <p><input type="checkbox"/> Increased <input type="checkbox"/> Absent <input type="checkbox"/> Unchanged <input type="checkbox"/> Decreased</p> <p>Your comments and impression?</p>	<p>15. Is there any abnormality of the following (circle applicable items and give details) on examination: No Yes</p> <p>(a) Eyes, ears, nose, mouth, pharynx? <input type="checkbox"/> <input type="checkbox"/> (If vision or hearing markedly impaired, indicate degree and correction.)</p> <p>(b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries? <input type="checkbox"/> <input type="checkbox"/></p> <p>(c) Nervous system (include reflexes, gait, paralysis)? <input type="checkbox"/> <input type="checkbox"/></p> <p>(d) Respiratory system? <input type="checkbox"/> <input type="checkbox"/></p> <p>(e) Abdomen (include scars)? <input type="checkbox"/> <input type="checkbox"/></p> <p>(f) Genitourinary system (include prostate)? <input type="checkbox"/> <input type="checkbox"/></p> <p>(g) Endocrine system (include thyroid and breasts)? <input type="checkbox"/> <input type="checkbox"/></p> <p>(h) Musculoskeletal system (include spine, joints, amputations, deformities)? <input type="checkbox"/> <input type="checkbox"/></p> <p>16. (a) Are there any hernias? <input type="checkbox"/> <input type="checkbox"/></p> <p>(b) Any hemorrhoids? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Are you aware of additional medical history? <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align:center;">(A confidential report may be sent to the Medical Director)</p>																	

Give details to "yes" answers:

<p>Urinalysis: S.G. _____ Occ. Blood _____</p> <p>Sugar _____ Albumin _____</p> <p>Time collected: _____ Is specimen being sent to Home Office Reference Laboratory? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Send Specimen to laboratory: (1) When instructed by agent (2) If applicant is age 60 or over (3) If history reveals G-U or C-V disease or disorder within 5 years (4) Regardless of age when total amount now applied for exceeds \$250,000.</p>
<p>Name of agent soliciting application: _____</p> <p>Reason for examination: <input type="checkbox"/> Life <input type="checkbox"/> Group</p> <p><input type="checkbox"/> Health <input type="checkbox"/> Employment <input type="checkbox"/> Other _____</p> <p>Examinations made at: <input type="checkbox"/> Examiner's Office</p> <p><input type="checkbox"/> Applicant's Home <input type="checkbox"/> Other _____</p>	<p>By (print name) _____ M.D. D.O.</p> <p>Signature _____ Para Med.</p> <p>Address _____</p> <p>Send exam to Agency Office or Home Office only. Examiner is welcome to call or write Medical Director with any information considered confidential.</p>