



**APPLICATION FOR LIFE INSURANCE - PART II**

PROPOSED INSURED				BIRTH DATE	
FIRST NAME		MIDDLE INITIAL	LAST NAME		SOCIAL SECURITY NO.
					MO. DAY YR.
<p>The following questions must be answered by each adult proposed for coverage, or by the applicant(s) for any proposed insured who is less than 15 years old.</p>				DRIVER'S LICENSE NUMBER	
<p>1. Have ever had or been treated for</p>				<p><b>Fully explain all "YES" answers below: (include diagnoses, dates, duration and names and addresses of all attending physician and medical facilities.)</b></p>	
			YES	NO	
a.	Disorder of eyes, ears, nose, or throat?		<input type="radio"/>	<input type="radio"/>	
b.	Dizziness, fainting, convulsions, paralysis or stroke, mental or nervous disorder?		<input type="radio"/>	<input type="radio"/>	
c.	Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, asthma, emphysema, tuberculosis or chronic respiratory disorder?		<input type="radio"/>	<input type="radio"/>	
d.	Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?		<input type="radio"/>	<input type="radio"/>	
e.	Jaundice, intestinal bleeding, ulcer, recurrent indigestion, chronic diarrhea, or the disorder of the stomach intestines, liver, or bladder?		<input type="radio"/>	<input type="radio"/>	
f.	Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?		<input type="radio"/>	<input type="radio"/>	
g.	Diabetes; thyroid other than endocrine disorders?		<input type="radio"/>	<input type="radio"/>	
h.	Neuritis, rheumatism, arthritis, gout, or any disorder of the muscles, bones, or joints?		<input type="radio"/>	<input type="radio"/>	
i.	Disorder of the skin or lymph glands?		<input type="radio"/>	<input type="radio"/>	
j.	Cancer or other tumor?		<input type="radio"/>	<input type="radio"/>	
k.	Allergies; anemia or other disorder of the blood?		<input type="radio"/>	<input type="radio"/>	
l.	Hepatitis in any form?		<input type="radio"/>	<input type="radio"/>	
m.	Have you ever been clinically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?		<input type="radio"/>	<input type="radio"/>	
2. Are you now under observation or treatment?			<input type="radio"/>	<input type="radio"/>	
3. Have you gained or lost more than 20 lbs. in the past year?			<input type="radio"/>	<input type="radio"/>	
4. Other than above, have you within the past 5 years:			<input type="radio"/>	<input type="radio"/>	
a.	Taken tranquilizers or "nerve pills"?		<input type="radio"/>	<input type="radio"/>	
b.	Used any type of drugs, narcotics or hallucinogens (including LSD, marijuana or heroin) not prescribed by a physician?		<input type="radio"/>	<input type="radio"/>	
c.	Had any mental or physical disorder not listed above?		<input type="radio"/>	<input type="radio"/>	
d.	Had a checkup, consultation, illness, injury, or surgery?		<input type="radio"/>	<input type="radio"/>	
e.	Been a patient in a hospital, clinic, sanatorium, or other medical facility?		<input type="radio"/>	<input type="radio"/>	
f.	Had electrocardiogram, X-ray, other diagnostic test?		<input type="radio"/>	<input type="radio"/>	
g.	Been advised to have any diagnostic test, hospitalization or surgery which was not completed?		<input type="radio"/>	<input type="radio"/>	
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?			<input type="radio"/>	<input type="radio"/>	
6. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?			<input type="radio"/>	<input type="radio"/>	
7. Family History: Diabetes, high blood pressure, heart disease, mental illness, or suicide?			<input type="radio"/>	<input type="radio"/>	
	AGE IF LIVING	CAUSE OF DEATH	AGE AT DEATH		
Father					
Mother					
Brothers & Sisters					
No. Living	_____				
No. Dead	_____				
8. In the past 24 months have you used tobacco in any form.				YES	NO
				<input type="radio"/>	<input type="radio"/>
9. a. Name and address and telephone number of your personal physician (If none, so state)				_____	
				_____	
b. Date and reason last consulted: results				_____	
				_____	
c. What treatment was given or medication prescribed?				_____	
				_____	
10. If applicable:				YES	NO
a. Have you ever had any disorder of menstruation, pregnancy or breast?				<input type="radio"/>	<input type="radio"/>
b. Are you now pregnant?				<input type="radio"/>	<input type="radio"/>
If yes, what is the pregnancy due date?				_____	

I represent that all statements and answers made in all parts of this application are full, complete and true to the best of my knowledge and belief. I agree that a copy of this Application Part II will form a part of any policy issued.

\_\_\_\_\_  
City and State where signed DATE

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Witness **X** M.D. **X**  
SIGNATURE OF PROPOSED INSURED OR PARENT OR GUARDIAN IF A JUVENILE  
ALAN-10018-30-XX

Any person who, with intent to defraud or knowing that he (she) is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I (We) authorize any records or knowledge of me (us) or my (our) health including information about drug use, alcoholism, and mental illness, to be given to AAA Life Insurance Company or its Reinsurers. This information may be provided by any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, the Veteran's Administration, insurance company, employer, the Medical Information Bureau, or other organization or person that has such information. I agree this authorization shall be valid for 26 months (from the date shown below). A copy of this authorization will be as valid as the original.

Date \_\_\_\_\_

**X**  
SIGNATURE OF PROPOSED INSURED

Witness **X** M.D. \_\_\_\_\_

DO NOT DETACH

