

PART II of application of insurance to
Proposed
Insured:

Male
 Female

Date of birth _____
 Mo. Day Year

First name Initial Last name

1. a. Name and address of your personal physician? _____
- b. Date and reason last consulted? _____
- c. What treatment was given or medication prescribed? _____
- d. What medications are you presently taking? _____

2. Within the past five years have you:
- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Consulted, been examined or been treated by any physician or practitioner?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had an X-ray, EKG, or any laboratory test or study?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had observation or treatment at a clinic, hospital, or sanitarium?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had or been advised to have a surgical operation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Had dizziness, shortness of breath, pain, or pressure in the chest?... | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" answers. (Identify question number, circle applicable items: Include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.)

3. Have you been told you had:
- | | | |
|--|--------------------------|--------------------------|
| a. Epilepsy, fainting spells, nervous or mental condition, paralysis, or any disease or abnormality of the brain or nervous system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart attack, murmur, high blood pressure, anemia, or any disease or abnormality of the heart, blood, or blood vessels?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, or respiratory system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ulcer, indigestion, colitis, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, or liver?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Urinary sugar, albumin or stone, syphilis, or disease or abnormality of the breasts, kidneys, prostate, urinary, or genital systems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes, gout, or any disease or abnormality of the thyroid or other glands?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any disease or abnormality of the eyes, ears, or skin?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cancer or tumor?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any physical deformity or defect?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

4. a. Within the past 10 years, have you used amphetamines, barbiturates, cocaine, heroin, morphine, LSD, marijuana, PCP, or any other hallucinogenic or narcotic drug?.....
- b. Have you ever received treatment or joined an organization for alcoholism or drug addiction?.....
- c. Has your weight changed more than 15 pounds in the past year?...

5. Family History: Diabetes, cancer, high blood pressure, heart or kidney disease, nervous or mental illness, or suicide?.....

| | Age | If living: State of health | Age at death | If deceased: Cause of death |
|--------------------|-----|-------------------------------|--------------|--------------------------------|
| Father | | | | |
| Mother | | | | |
| Brothers & sisters | | | | |

I declare that, to the best of my knowledge and belief, the statements and answers in Part II of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company any such information. This authorization is good for 30 months from the application date.

To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information.

A photographic copy of this authorization shall be as valid as the original.

Signed at: (City & state) _____ On _____ 20____

Signature of witness

Signature of Proposed Insured

Medical Examiner's report to be filled out in private (Not a part of the application)
 The questions on the reverse side must be completed and signed before the Medical Examiner.
 The Medical Examiner must ask the Proposed Insured each question and record the answer.

1. Name of Proposed Insured _____

2. Height _____ 3. Weight _____
 Ft. In. Lbs. Did you weigh? _____

4. a. Chest expanded _____ in./ **Males only**
 b. Chest contracted _____ in./
 C. Abdomen _____ in./

5. Blood pressure Systolic _____
 Diastolic _____
 (Phase V) _____

| 6. Pulse rate | Before exercise | Immediately after | Three minutes after |
|---------------|-------------------------|-------------------|---------------------|
| | Irregularities (minute) | | |

7. Urinalysis: (dipstick method is adequate)
 Amount of albumin _____ Amount of sugar _____
 Other abnormalities noted _____

Instruction to Examiner
 Complete questions above and mail specimen for
 laboratory analysis to:
 Clinical Reference Lab
 8433 Quivira St., Lenexa, KS 66216

8. a. Has Proposed Insured smoked one or more cigarettes in the last 12 months? Yes No

b. Any other tobacco use?

9. a. Does Proposed Insured consume alcoholic beverages? Yes No

b. If yes, how many drinks per day? _____

10. a. Does Proposed Insured engage in regular exercise? Yes No

b. If yes, what type and how often? _____

11. Is appearance unhealthy or older than stated? Yes No

Details - Please give full details of adverse findings and opinions.

M.D. only complete this section.

12. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Brain, nervous system? (Test reflexes and coordination)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ears, nose, eyes, throat, teeth, or gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Thyroid or lymph glands?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart, blood vessels?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you find any abnormality of heart size, rhythm, or sounds, please complete Question number 14.) | | |
| e. Lungs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stomach or abdominal organs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Genito-urinary system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Skin or extremities?..... | <input type="checkbox"/> | <input type="checkbox"/> |

13. a. Is there a hernia? (If so, describe it.).....

b. Is there any evidence of varicose veins, ulcers, hemorrhoids?.....

c. Do you know any facts about this risk not brought out above?.....




14. To be completed if question 12d. is answered "Yes"

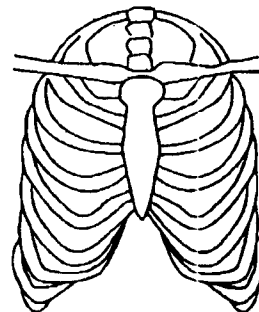
a. Is there a murmur?.....

b. If yes, murmur is:
 Apical Systolic Constant Soft (Gr. 1-2)
 Basal Presystolic Inconstant Mod. (Gr. 3-4)
 Diastolic Loud (Gr. 5-6)

c. On exercise, does the murmur
 Intensify?
 Decrease?
 Disappear?

d. Show location of murmur:

Apex by X
 Area of murmur by outline 
 Point of greatest intensity 
 Transmission 



e. What is your impression of the murmur? _____

Examination was made in private at:

- My office
- Residence of Proposed Insured
- Place of business of Proposed Insured.

At _____ AM on _____, 20____
 PM

Name of agent requesting exam _____

If not an appointed examiner of the Company: Medical school where graduated _____

Date of graduation _____ Name of companies for which you examine: _____

 ✕ _____

Signature of examiner

Address _____

City _____ State _____ Zip code _____