

STATEMENTS TO THE MEDICAL EXAMINER

In Continuation of and Forming a Part of My Application for Insurance to
American-Amicable Life Insurance Company of Texas

PART TWO

Mail examination to: Underwriting Department / P.O. Box 2549 / Waco, Texas 76702-2549

1. Applicant (Please Print) _____	Birth Date: Month Day Year / /	Driver's License # SS# — —	State
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2. (a) Name and address of your personal physician? _____
 (If none, so state)
- (b) Date and reason last consulted? _____
- (c) What treatment was given or medication prescribed? _____
- (d) List all current medications including herb and vitamin supplements. _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 3. To the best of your knowledge and belief do you have, or have you ever had, or been treated for (circle condition that applies): | | |
| (a) Asthma, pneumonia, bronchitis, emphysema, tuberculosis or any disease or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Dizziness, epilepsy, seizure, paralysis, head injury, or any mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Albumin, protein, sugar or blood in urine; any disease or disorder of the kidneys or genitourinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Arthritis or any disease or disorder of the muscles, bones, joints, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Any disease or disorder of the ears, eyes, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Chest pains, heart attack, stroke, transient ischemic attack (TIA), high blood pressure, shortness of breath, heart murmur, phlebitis, blood clot; any disease or disorder of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Cirrhosis, hepatitis, or any disease or disorder of the gastrointestinal tract? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Malignancy, cancer or other tumors or cyst? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Diabetes, thyroid, or endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia or any disease or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any disease or disorder of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever used:
Heroin, morphine, cocaine, LSD, marijuana or abused prescription medication? (If Yes, indicate amount and how often and date last used) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. (a) Do you currently drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, circle type: beer, wine, liquor. Indicate amount and frequency) | | |
| (b) Have you ever received treatment for excessive drug or alcohol usage? | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, give date of treatment and last usage) | | |
| 7. (a) Have you been arrested in the past 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, give details to include when, where, charges, and final outcome) | | |
| (b) Have you had a DWI or DUI or had your Driver's License suspended or revoked in the past 10 years? (If Yes, explain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a tattoo? (If Yes, date done) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the past 5 years, have you consulted, or been treated or examined by any physician, psychologist, psychiatrist or practitioner not named above for any cause not recorded above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you used tobacco or any nicotine products in any form within the past twelve (12) months? (If Yes, type and amount, if No, date last used) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If the applicant is a woman: Are you currently menstruating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the natural parent, brother or sister of the proposed insured ever had tuberculosis, diabetes, cancer, heart disease, kidney disease or mental illness? ... | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Siblings			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief. I agree that these statements and answers are to be considered as the basis of any insurance written hereon.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has knowledge or records of me and my health to give such information to American-Amicable Life Insurance Company of Texas and its reinsurers.

Signed at _____ this _____ day of _____, _____ Year

Witness _____ X _____
 Examiner Signature of Applicant

PART THREE

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

13. (a) Height (In Shoes)	Weight (Clothed)		Males Only:			Details of "Yes" answers (identify item).
			Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	
ft. in.	lbs.		in.	in.	in.	
(b) Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No			(c) Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No						
15. Pulse:						
Rate		At Rest		After Exercise		3 Minutes Later
Irregularities per min.						
16. Blood Pressure:						
Systolic		1 _____		2 _____		3 _____
Diastolic (5th phase, end of sound)						
If over 140 or 90 or under treatment report several readings.						
17. Is applicant presently under anti-hypertensive medication? <input type="checkbox"/> Yes <input type="checkbox"/> No						

PHYSICIAN STATEMENT

18. Is there evident arteriosclerosis? Yes No

19. Heart:
Is there any:

Enlargement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea? <input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema? <input type="checkbox"/> Yes <input type="checkbox"/> No

(Describe below — if more than one, describe separately.)

Location	Murmur 1	Murmur 2	Indicate:	
Constant	<input type="checkbox"/>	<input type="checkbox"/>		MCL ▼
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	X
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	○
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	○
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	▶
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>		
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>		
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>		
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>		
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>		
After exercise:				
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Absent	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		



20. Is there on examination any abnormality of the following: (Circle applicable items and give details.)	Yes	No	
(a) Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>	
(If vision or hearing markedly impaired, indicate degree.)			
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>	
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Are there any hernias?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Are you aware of additional medical history?	<input type="checkbox"/>	<input type="checkbox"/>	

(A confidential report may be sent to the Medical Director.)

Urinalysis: Specific Gravity	Albumin	Sugar	IMPORTANT Please forward urine and/or blood specimen(s) to the Laboratory shown on the container provided.
(a) Is specimen being sent? <input type="checkbox"/> Yes <input type="checkbox"/> No			(b) Blood Study: Is sample being sent to lab shown on container? <input type="checkbox"/> Yes <input type="checkbox"/> No

I CERTIFY I made this examination in private at My office, Applicant's office, Applicant's home. at _____ A.M. P.M.
in _____ City _____ State _____ this _____ day of _____,

Signature: _____ Address: _____
Medical Examiner

EXAMINER _____ INSURER _____
ADDRESS _____ ADDRESS _____

**NOTICE AND CONSENT FOR BLOOD TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the insurer named above ("the insurer") has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The AIDS-related virus (HIV) antibody test detects the presence of antibodies, naturally occurring proteins in the blood produced by the body in response to the AIDS-related virus, by using a simple blood test. This is **not** a test for AIDS. The test does not tell you if you have AIDS or an AIDS-related condition (ARC); it does show whether you have been infected with the virus that can cause AIDS. This test is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders. Many public health organizations have recommended that before taking a test to determine the probable causative agents of AIDS, a person should seek counseling in order to become informed concerning the implications of such a test. In the event the test result is positive, we urge you to contact a private physician, the county department of health, local medical societies, or alternative test sites for appropriate counseling at your expense, subsequent to being tested. A listing of public and private health care facilities providing such counseling is attached.

Positive HIV antibody/antigen test results do not mean that you have AIDS but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. If the insurer is a member of the Medical Information Bureau ('MIB, Inc. '), and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific blood test abnormality. The generic code may also be disclosed to any member company that receives an Application for health or life insurance on your life. Other insurers to whom you may apply for insurance in the future will probably require an HIV-related test when they discover that a nonspecific blood disorder has been reported. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the test have been done except as may be required or permitted by law or as authorized by you.

If your test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal you will be notified. Because a trained person such as your physician should deliver that information so that you can understand clearly what the test result means, it is important that you list your private physician so that the insurer can have that person tell you the test result and explain its meaning. In the event you do not designate a physician, the insurer will contact you. The insurer urges you to seek counseling as instructed above.

Physician _____ Address _____

I have read and I understand this Notice and Consent for Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of blood and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original.

Name of Proposed Insured _____ Date of Birth _____

Signature of Proposed Insured or Parent/Guardian _____ Date _____

Test Consent Form Counseling Resources

Pursuant to California Assembly Bill 3305, (California Insurance Code § 799 eff. 1/1/89), we are obligated to provide this list of counseling resources prior to obtaining consent for HIV-antibody testing. This list of resources has been compiled from a list provided by the California Department of Health Services/Office of AIDS (DHS/OA). The DHS/OA has contracts with numerous counties and clinics throughout California to provide HIV testing, education and information.

SOUTHERN CALIFORNIA

Kern County Health Dept.
1700 Flower Street
Bakersfield, CA 93305
(805) 861-3651 Ext. 462

The Center
2017 East 4th Street
Long Beach, CA 90714-1001
(213) 427-7421

The Edleman Center
1213 North Highland Avenue
Los Angeles, CA 90038
(213) 464-7400

Ruth Temple Health Center
3834 Western Avenue
Los Angeles, CA 90062
(213) 730-3838

Edward R. Roybal
Comprehensive Health Center
245 South Fetterly Avenue
Los Angeles, CA 90022
(213) 260-3035

Riverside Health Center
1520 Linden Street
Riverside, CA 92507
(714) 787-2042

San Bernardino County
Health Department
799 East Rialto Avenue
San Bernardino, CA 92415-0010

Santa Barbara Health Serv.
315 Camino Del Remedio
Santa Barbara, CA 93110
(805) 681-5260

Ventura Co. Health Dept.
3147 Loma Vista Road
Ventura, CA 93003
(805) 652-5928

Valley Community Clinic
5648 Vineland Avenue
North Hollywood, CA
(818) 763-5963

SAN DIEGO, IMPERIAL, AND ORANGE COUNTIES

Imperial Co. Health Dept.
935 Broadway
El Centro, CA 92243
(619) 339-4438

Orange County
Health Department
1725 West 17th Street
Santa Ana, CA 92706
(714) 834-3816

J.B. Askew Building
1700 Pacific Highway
San Diego, CA 92101
(619) 236-2264

East San Diego H.C.
5202 University
San Diego, CA 92103
(619) 582-6433

Oceanside Health Center
104 South Barnes Street
Oceanside, CA 92054
(619) 967-4401

El Cajon Health Center
113 East Douglas Avenue
El Cajon, CA 92020
(619) 579-4446

Escondido Health Center
606 East Valley Parkway
Escondido, CA 92025
(619) 740-4000

North San Diego H.C.
2440 Grand Avenue
San Diego, CA 92109
(619) 274-1223

South Bay Health Center
263 Fig Avenue
Chula Vista, CA 92010
(619) 691-4750

Vista Health Center
200 West Broadway
Vista, CA 92083 1221
(619) 945-1333

NORTHERN CALIFORNIA

Central Health Center
470 27th Street
91601 Oakland, CA 94612
(415) 874-7196

Humboldt Co. Health Dept.
529 I Street
Eureka, CA 95501
(707) 445-6200

District Health Center #1
3850 17th Street
San Francisco, CA 94114
(415) 621-4858

Monterey County Health Dept.
Seaside Health Center
1292 Olympia Avenue
Seaside, CA 93955
(408) 755-4500

San Joaquin Health Dept.
1601 East Hazelton
Stockton, CA 95205
(209) 468-3400

San Mateo County Health Dept.
225 West 37th Avenue
San Mateo, CA 94403
(415) 573-2516

Santa Clara County Health Dept.
V.D. Clinic
976 Lenzen Avenue
San Jose, CA 95126
(408) 299-5913

Shasta County Health Dept.
2650 Hospital Lane
Redding, CA 96001
(916) 225-5591

Stanislaus Health Dept.
820 Scenic Drive
Modesto, CA 95350
(209) 525-7339

Davis Community Clinic
620 G Street
Davis, CA 95616
(916) 666-8649

Fresno Co. Health Dept.
Fulton Mall
Fresno, CA 93721
(209) 445-3416

Merced County Health Dept.
240 East 15th Street
Merced, CA 95341
(209) 385-770

Capital Health Clinic
1500 C Street
Sacramento, CA 95814
(916) 440-5302