

PROPOSED INSURED INFORMATION

Name of Proposed Insured _____

Date of Birth (mm/dd/yyyy) / / _____

1. a. Name, address and phone number of your personal physician? (If none, so state) _____

b. Date and reason last consulted? _____

c. Treatment given or medication prescribed? _____

2. Have you ever consulted a physician for, been treated for, or had any known indication of: **YES NO**

a. Any disorder of the eyes, ears, nose or throat?

b. Dizziness, fainting, convulsions, headache, speech disorder, paralysis, stroke or nervous disorder?

c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?

d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?

e. Hepatitis, cirrhosis of the liver, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gall bladder?

f. Sugar, albumin, blood or pus in urine; sexually transmitted disease (STD); stone or other disorder of the kidney, bladder, prostate or reproductive organs?

g. Diabetes, thyroid or other endocrine disorders?

h. Neuritis, sciatica, rheumatism, arthritis, gout, or other disorders of the muscles, bones, joints, back or spine?

i. Any disorder of the skin or lymph glands, cyst, tumor or cancer?

j. Allergies; anemia or other disorder of the blood?

k. Any psychiatric, emotional or mental health condition?

3. In the past five years, have you:

a. Been treated or joined an organization for alcohol or drug addiction or abuse?

b. Been convicted of driving while intoxicated?

c. Been convicted of an illegal use, sale or possession of barbiturates, sedatives, heroin, morphine, LSD, marijuana, cocaine or amphetamines?

4. a. Do you currently use tobacco or a nicotine product in any form? (If Yes, state type)

b. Have you used tobacco or any nicotine product within the last 12 months? (If Yes, state date last used)

5. Are you now under observation or taking treatment?

6. Have you had any change in weight in the past year?

7. Other than above, have you within the past 5 years:

a. Had a checkup, consultation, illness, injury or surgery?

b. Been a patient in a hospital, clinic, sanitarium or other medical facility?

c. Had an electrocardiogram, x-ray, or other lab test?

d. Been advised to have any diagnostic test, hospitalization or surgery that has not been completed?

8. Have you ever, for mental or physical health reasons:

a. Received disability benefits, compensation or a pension?

b. Had a military service deferment, rejection or discharge?

9. Have you been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC)?

10. Have any of your parents, brother or sisters had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, committed suicide, or sudden death?

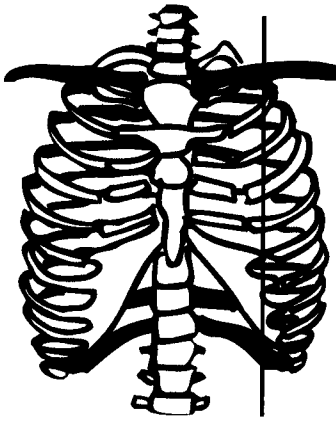
REMARKS: Give details to all YES answers. (Identify question number and circle applicable items.) Include all dates, diagnoses, durations, outcomes and patient ID (if known). Give name, address and phone number of all attending physicians and medical facilities. Attach extra sheets if needed. (Additional sheets must be signed and dated by the proposed insured and medical examiner)

To the best of my knowledge and belief, the statements and answers shown above are true and complete.

Date Signed _____ Signature of Proposed Insured _____ Signature of Medical Examiner _____

MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

101.	a.	Height (In Shoes)	ft. in.	Weight (Clothed)	lbs.	Chest (Full Inspiration)	in.	Chest (Forced Expiration)	in.	Abdomen (At Umbilicus)	in.					
	b.	Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Details of "Yes" answers. (Identify item.)										
102.	Blood Pressure (Record ALL readings) Repeat Blood Pressure if first over 135/85.															
		Systolic														
		Diastolic {	4 th phase													
			5 th phase													
103.		Pulse		At Rest		After Exercise		3 Minutes Later								
		Rate:														
		Irregularities per minute:														
104.	a.	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)														
	b.	Indicate:		Location												
		Apex by X		Constant	<input type="checkbox"/>	<input type="checkbox"/>										
		Murmur area by ()		Inconstant	<input type="checkbox"/>	<input type="checkbox"/>										
		Point of greatest intensity by O		Transmitted	<input type="checkbox"/>	<input type="checkbox"/>										
		Transmission by →		Localized	<input type="checkbox"/>	<input type="checkbox"/>										
				Systolic	<input type="checkbox"/>	<input type="checkbox"/>										
				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"/>											
	c.	Your impression?		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"/>										
105.		Is there on examination, any abnormality of the following:														
	a.	Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction)	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	b.	Skin (including scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	c.	Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	d.	Respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	e.	Abdomen (including scars)?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	f.	Genitourinary system (include prostate)?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	g.	Endocrine system (include thyroid and breasts)?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	h.	Musculoskeletal system (include spines, joints, amputations, deformities)?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
106.	a.	Are there any hernias?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	b.	Any hemorrhoids?	<input type="checkbox"/> Yes <input type="checkbox"/> No													
107.		Are you aware of additional medical history? (A confidential report may be sent to our Medical Director)														
		<input type="checkbox"/> Yes <input type="checkbox"/> No														
108.		Urinalysis	Specific Gravity	Albumin	Sugar											
		Is specimen being sent to lab? <input type="checkbox"/> Yes <input type="checkbox"/> No SEND SPECIMEN TO APPROPRIATE LAB IF: a.) application is \$100,000 or over; b.) applicant is over age 60; c.) blood pressure is abnormally high; d.) albumin or sugar is found or any history of; e.) any urinary abnormality or history of urinary impairment.														

I CERTIFY that I have carefully examined (print full name) _____ of _____ (address) _____ in private, and not in the presence of any other person except as stated in space above, at (give actual place of examination) _____ this _____ day of _____ 20____ at _____ o'clock a.m./p.m., that I have asked each question exactly as set forth on the other side of this sheet and that the answers thereto are in my handwriting, and are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this and on the reverse side, and believe them to be complete and true.

Address _____ M.D. _____

TO THE MEDICAL EXAMINER: Any erasures or alterations in this report should be initialed by you. Please forward this report, or any information which you prefer not to embody in this report, without delay.

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

The HIV Antibody Test

To evaluate your insurability, American Fidelity Assurance Company (the Insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A series of three tests, two ELISA tests and one Western Blot Assay, will be performed by a licensed laboratory through a medically accepted procedure. These tests directly identify AIDS viral particles.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous 3-6 months.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover the results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Meaning of Positive Test Result

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 test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a possible positive test result:

Consent for Testing

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I have received the Red Cross brochure describing HIV, its causes and symptoms, the manner in which it is spread, the test or tests used to detect HIV or the HIV antibody, and what a person can do whose test results are positive or negative. I also understand that I can contact my private physician or any of the resources listed in the Counseling Resources List for further information.

I have received a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

Name and address of Proposed Insured:
