

APPLICATION TO AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY
(To be Completed By the Medical Examiner)

Proposed Insured First name Middle Initial Last name Birth Date: Month Day Year

- 1. a. Names and addresses of your personal physicians (If none, so state)
b. Date and reason last consulted
c. What treatment was given or medication prescribed?

- 2. Have you within the last ten years been diagnosed or treated for:
a. Disease of eyes, ears, nose or throat?
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disease?
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels?
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or disease of the stomach, intestines, liver or gallbladder?
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disease of kidney, bladder, prostate, reproductive organs or breast?
g. Diabetes; thyroid or other endocrine disorders?
h. Neuritis, sciatica, rheumatism, arthritis, gout or disease of the muscles or bones, including the spine, back or joints?
i. Deformity, lameness or amputation?
j. Disease of skin, lymph glands; cyst, tumor or cancer?
k. Allergies; anemia or other disease of the blood (except HIV infection)?
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)?
m. Alcoholism or drug usage?
3. Are you now pregnant or have you had any irregularity of menstruation or complications of pregnancy?
4. Are you now under observation or taking treatment?
5. Have you had any change in weight in the past year?
6. Other than above, have you within the past 5 years:
a. Had a checkup, consultation, illness, injury, surgery?
b. Been a patient in a hosp., clinic, sanatorium or other medical facility?
c. Had electrocardiogram, X-ray, other diagnostic test?
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?
7. Have you used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? If "Yes", specify each type, frequency, amount and date of last use.
8. Have you within the last ten years requested or received a pension, benefits or payment because of an injury, sickness or disability?

Table with 5 columns: Family History, Age if Living?, Past or Current Condition or Cause of Death?, Age at Death?, Age at Onset?. Rows include Father, Mother, Brothers and Sisters, No. Living, No. Dead.

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.)

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. I hereby declare that the statements and answers shown above have been transcribed as given by me and that they are true and complete to the best of my knowledge and belief; and I agree that this application shall become a part of the policy for which this application is made and that any policy which may issue will issue on the basis of my representations. I further agree that no Medical Examiner or field representative of the Company has the authority to waive the answer to any question in this application or to modify this application, or to bind the Company in any way by making any promise or representation, or by giving or receiving any information which is not set out in writing in this application.

Dated at this day of

Witnessed by (Medical Examiner)

Signature of Proposed Insured

Signature of Parent or Guardian required if Proposed Insured has not reached his sixteenth birthday.

LOCAL OFFICE TO COMPLETE THIS BLOCK	Name of Person to be Examined _____	Local Office (Name and Code) _____
	\$ _____	Date of Application _____
	Total Initial Amount of Insurance	Agency No. _____

MEDICAL EXAMINER'S REPORT

<p>10. a. Height (in shoes) _____</p> <p style="text-align: center;">ft. in.</p> <p>Weight (Clothed) _____</p> <p style="text-align: center;">lbs.</p>	<p>Males Only:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Chest (Full Inspiration) _____</td> <td style="width:33%;">Chest (Forced Expiration) _____</td> <td style="width:33%;">Abdomen, at Umbilicus _____</td> </tr> <tr> <td style="text-align: center;">in.</td> <td style="text-align: center;">in.</td> <td style="text-align: center;">in.</td> </tr> </table>	Chest (Full Inspiration) _____	Chest (Forced Expiration) _____	Abdomen, at Umbilicus _____	in.	in.	in.	<p>Details of "Yes" answers. (Identify item.)</p>																																																																
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<p>b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																																								
<p>11. Blood Pressure (If pressure over 140/90 give additional readings)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Systolic _____</td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> <tr> <td>Diastolic 5th phase _____</td> <td></td> <td></td> </tr> </table>			Systolic _____			Diastolic 5th phase _____																																																																		
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<p>14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)</p> <table style="width:100%;"> <tr> <td style="width:80%;">a. Eyes, ears, nose, mouth, pharynx? _____</td> <td style="width:5%;">Yes</td> <td style="width:15%;">No</td> </tr> <tr> <td>(If vision or hearing markedly impaired, indicate degree and correction.)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Nervous system (include reflexes, gait, paralysis)? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Respiratory system? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Abdomen (include scars)? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f. Genitourinary system (include prostate)? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g. Endocrine system (include thyroid and breasts)? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h. Musculoskeletal system (include spine, joints, amputations, deformities)? _____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			a. Eyes, ears, nose, mouth, pharynx? _____	Yes	No	(If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>	b. Skin (incl. 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 (include scars)? _____	<input type="checkbox"/>	<input type="checkbox"/>	f. Genitourinary system (include prostate)? _____	<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"/>																																											
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<p>15. a. Are there any hernias? _____</p> <p>b. Any hemorrhoids? _____</p>																																																																								
<p>16. Are you aware of additional medical history? _____</p> <p style="text-align: center;">(A confidential report may be sent to the Medical Director)</p>																																																																								

URINALYSIS >	Are you satisfied it is authentic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specific Gravity _____	Albumin (even a trace) _____	Sugar (even a trace) _____	Occult blood? _____	Are you mailing specimen to Home Office? (See instructions below.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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NOTICE—Forward Specimen to Home Office, if

- a. Albumin or sugar is found, or there is any history or presence of hypertension (blood pressure exceeds 150/90), heart or genito-urinary disorder.
- b. Amount of insurance (listed above) is \$100,000 or more through age 55; \$50,000 or more ages 56 and over.
- c. Agent requests it when examination arranged.

I certify that the proposed insured was examined by me in private at my office applicant's home applicant's place of work

this _____ day of _____ at _____ o'clock P.M.

Signature of Examiner _____ Address _____