



- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- AIG Life Insurance Company, Wilmington, DE

Member companies of American International Group, Inc.

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Personal Information

1. Proposed Insured (Complete separate Part B for each Proposed Insured)

Name _____ Date of Birth _____ Social Security # _____

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

2. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). (If no personal physician, provide name, address and phone number of doctor last seen.)

Name _____ Phone (____) _____

Address _____ City, State _____ ZIP _____

Date, reason, findings and treatment at last visit _____

3. Build

A. Admitted Height and Weight _____ ft. _____ in. _____ lbs

(Examiners: Also record measured height and weight on Exam page 1.)

B. Has the Proposed Insured had any weight change in excess of 10 lbs. in the past year? yes no If yes, complete the following:

Loss _____ lbs. Gain _____ lbs. Reason _____

4. Family History

Age if Living	Age at Death	Cause of Death	History of Heart Disease?	History of Cancer?
Father _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Mother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Brother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Brother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Sister _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Sister _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____

5. Personal Health History

A. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

- 1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? yes no
- 2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? yes no
- 3) cancer, tumors, masses, cysts or other such abnormalities? yes no
- 4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? yes no
- 5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? yes no
- 6) a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? yes no
- 7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? yes no
- 8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder? yes no
- 9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? yes no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

B. Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

C. Has the Proposed Insured in the past three years had but NOT sought treatment for:

- 1) fainting spells, nervous disorder, headaches, convulsions or paralysis? yes no
- 2) any pain or discomfort in the chest or shortness of breath? yes no
- 3) disorders of the stomach, intestines or rectum, or blood in the urine? yes no

(If yes, list condition such as: date of first occurrence; symptoms; and how treated.)

Details _____

D. Has the Proposed Insured ever:

- 1) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? yes no
- 2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? yes no

(If yes answered to D1 or D2, please provide details below.)

Type of drug(s)/alcohol product(s) _____ Date last used _____
Name(s) of doctor/facility _____ Phone () _____
Address _____ City, State _____ ZIP _____
Treatment Dates _____
Support group(s) _____ Last date attended _____
Details of any drug or alcohol related arrests _____

5. Personal Health History (continued)

E. Has the Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

F. Other than previously stated, in the past 10 years, has the Proposed Insured:
1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

2) been advised to have any diagnostic test, hospitalization or treatment that was NOT completed? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; recommended tests, medications or treatment.)

Details _____

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? yes no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

G. Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

Physical Measurements

1. Proposed Insured

- A. Name _____
- B. Build: Measured Height (*in shoes*) _____ ft. _____ in. Weight (*clothed*) _____ lbs (*Please weigh insured.*)
- C. Are you currently taking Blood Pressure Medication(s)? yes no
 Medication(s) _____

Blood Pressure (*Record all readings.*) If blood pressure exceeds 140/90, repeat reading at end of examination.*

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th Phase BP				
Pulse Rate				
Irregularities Per Min.				

- D. Did you weigh Proposed Insured? yes no
- E. Have any of the following been completed in conjunction with this exam?
 Blood Urine EKG Stress Test Chest x-ray
- F. Is appearance unhealthy or older than stated age? yes no
- G. Do you have any pertinent information not disclosed previously?
 (*Details of yes answers to questions F and G*) yes no

- H. Are you related to the Proposed Insured by blood or marriage or do you have any business or professional relationship with the Proposed Insured? (*If yes, explain.*) yes no

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart

- a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? yes no
- b. Is heart enlarged? (*If yes, describe.*) _____ yes no
- c. Is murmur present? (*If yes, complete 2d.*) _____ yes no
- d. Before exercise, murmur is:
 Constant Transmitted to where? _____
 Inconstant Localized at: Apex Base Elsewhere
 Systolic (*Give details.*) _____
 Diastolic Murmur grade: (*Please circle*) 1/6 2/6 3/6 4/6 5/6 6/6
 After valsalva, murmur is:
 Unchanged Decreased Increased Absent

Your impression _____

Report by Examining Medical Doctor (continued)

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below.)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction.)* yes no

Details _____

b) Endocrine system *(including thyroid)?* yes no

Details _____

c) Nervous system *(including reflexes, gait, paralysis)?* yes no

Details _____

d) Respiratory system? yes no

Details _____

e) Abdomen *(including scars)?* yes no

Details _____

f) Genito-urinary system? yes no

Details _____

g) Skin *(including scars), lymph nodes, blood vessels (including varicose veins)?* yes no

Details _____

h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* yes no

Details _____

Signature

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____ day of _____, 20_____, at _____ am pm

Location of Exam _____ **Paramed: Use company stamp below.**

Examiner's Address _____

Examiner's Phone # () _____

Examiner's Name _____

Examiner's Signature **X** _____

(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion.)



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- The United States Life Insurance Company in the City of New York, New York, NY

Members of American International Group, Inc.

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Notice and Consent for Bodily Fluid Testing for AIDS Virus (HIV) Antibody/Antigen Aids Related Testing

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form, you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having a abnormal HIV antibody test because many abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, 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.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

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. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-752-AIDS.

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he/she can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or entity:

Name of physician or other person/entity _____

Street address _____

City _____ State _____ Zip _____

Informed Consent

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

Proposed Insured _____ Date of Birth _____

Signature of Proposed Insured _____ Date _____ State of Residence _____

Signature of Witness _____