

**MEDICAL EXAMINATION  
AMERICAN HERITAGE LIFE INSURANCE COMPANY  
1776 American Heritage Life Drive  
Jacksonville, Florida 32224-6688**

Proposed Insured \_\_\_\_\_ Birthdate \_\_\_\_\_  
 \_\_\_\_\_  
 First Name Middle Name Last Name Month Day Year

- 1.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? \_\_\_\_\_

2. Have you ever been treated for or ever had any known indication of:	Yes	No	<b>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.</b>																								
a. Disorder of eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
f. Sugar, Albumin, blood or pus in urine, sexually transmitted disease; stone or other disorder of kidney, bladder prostate, breasts, or reproductive organs?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
g. Diabetes, thyroid, or other endocrine disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
i. Deformity, lameness or amputation?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
j. Disorder of skin, lymph glands, cyst, tumor or cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
k. Allergies; anemia, or other disorder of the blood?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
l. Use of barbiturates, or amphetamines; marijuana, or any other hallucinatory drugs or heroin opiates, or other narcotics, except as prescribed by a doctor, or been treated or counseled for alcoholism?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
m. Any mental or physical disorder not listed above?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
3. Are you now under observation or taking treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
4. Have you had any change in weight in the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
5. Other than above, have you within the past 5 years:																											
a. Had a checkup, consultation, illness, injury, surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	10.a. Within the past 10 years, have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?..... <input type="checkbox"/> <input type="checkbox"/>																								
b. Been a patient in a hospital, clinic, sanitarium, or other medical facility?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
c. Had an electrocardiogram, X-ray, other diagnostic test?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	b. Within the past 2 years, have you had persistent cough, pneumonia, chest discomfort, muscle weakness, Kaposi's Sarcoma, unexplained weight loss of 10 pounds or more, swollen glands, patches in mouth, visual disturbances, or recurring diarrhea, fever or infection?..... <input type="checkbox"/> <input type="checkbox"/>																								
7. Have you ever requested or received a pension, benefits or payments because of an injury, sickness or disability?..	<input type="checkbox"/>	<input type="checkbox"/>																									
8. Family History: Tuberculosis, Diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?.....	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <thead> <tr> <th></th> <th>Age, if Living</th> <th>Cause of Death</th> <th>Age at Death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers &amp; Sisters</td> <td></td> <td></td> <td></td> </tr> <tr> <td>No. of Living _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>No. Dead _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Age, if Living	Cause of Death	Age at Death	Father				Mother				Brothers & Sisters				No. of Living _____				No. Dead _____			
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Father																											
Mother																											
Brothers & Sisters																											
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No. Dead _____																											
9. Are you a cigarette smoker?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
If yes, number of packs per day _____																											
Have you been a cigarette smoker and quit?.....	<input type="checkbox"/>	<input type="checkbox"/>																									
If yes, when did you last smoke? _____																											

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

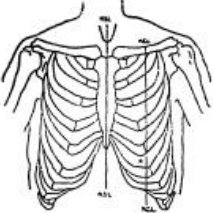
Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ .  
 Witness \_\_\_\_\_ M.D. \_\_\_\_\_  
 (Signature of Medical Examiner) (Signature of Proposed Insured)

**AUTHORIZATION STATEMENT**

AUTHORIZATION: I hereby 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 American Heritage Life Insurance Company or its reinsurers any such information. I hereby acknowledge receipt of the Pre-Notice and Important Notice forms. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent on whom insurance is being requested. This authorization shall be valid for 2 years from the date of signing.

Date \_\_\_\_\_ Signature of Examining Physician Tax I.D.# \_\_\_\_\_ M.D. \_\_\_\_\_ Signature of Proposed Insured \_\_\_\_\_

**MEDICAL EXAMINER'S REPORT**

11a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen (at Umbilicus)	Details of "yes" answers. (Identify item.)
ft.    in.	lbs.	in.	In.	in.	
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. Blood Pressure (Record ALL readings)					
Systolic					
Diastolic (4 <sup>th</sup> phase)					
Diastolic (5 <sup>th</sup> phase)					
13. Pulse:					
	At Rest	At Exercise	3 minutes Later		
Rate					
Irregularities per min.					
14. 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			Indicate:		
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by: <input checked="" type="checkbox"/> X		
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by: <input type="checkbox"/> O		
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by: <input type="checkbox"/> ■		
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by: <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 (Or. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>			
Mod. (Or. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>			
Loud (Or. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>			
After exercise:	<input type="checkbox"/>	<input type="checkbox"/>			
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"/>			
For comments and your impression?					
15. 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"/>	<input type="checkbox"/>		
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
c. Nervous system (include reflexes, gait, paralysis)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
d. Respiratory system?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
e. Abdomen (include scars)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
f. Genitourinary system (include prostate)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
g. Endocrine system (include thyroid and breasts)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
h. Musculoskeletal system (include spine, joints, amputations, deformities)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16.a. Are there any hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No					
b. any hemorrhoids?..... <input type="checkbox"/> <input type="checkbox"/>					
17. Are you aware of additional medical history?..... <input type="checkbox"/> <input type="checkbox"/> (a confidential report may be sent to the Medical Director)					
18. Are you alone with proposed insured and unrelated to both the proposed insured and agent?..... <input type="checkbox"/> <input type="checkbox"/>					

**URINALYSIS**

a. Specific gravity?	b. Reaction?
c. Albumin?	Test used?
d. Sugar?	Test used? (Make note of slightest trace of albumin or sugar found on examination)
e. Has anyone ever claimed to have found casts, albumin or sugar in proposed insured's urine?	
f. Are you forwarding a specimen of proposed insured's urine? (see note bottom of page)	
g. <b>Always forward a urine specimen to Home Office Reference Lab. If no specimen will be forwarded, please explain circumstances.</b>	

Name of Agent \_\_\_\_\_

I certify that I have carefully examined \_\_\_\_\_ of \_\_\_\_\_  
(City and Street Address)

my office  
in private, at his/her place of business this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ a.m.  
his/her home \_\_\_\_\_ p.m.

Signature of Examiner \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_  
(Please print)      TAXPAYER IDENTIFICATION NUMBER \_\_\_\_\_

Review report carefully for completeness of all sections, then mail directly and without exception to the Medical Director at the Home Office of the Company  
**THE COMPANY APPRECIATES CONFIDENTIAL INFORMATION ALWAYS**



Workplace Division

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6688  
1-800-521-3535

### **NOTICE AND CONSENT FOR URINE OR BLOOD TESTING TO DETECT INFECTION BY THE AIDS VIRUS (HIV)**

To evaluate your insurability, the Insurer named above (the Insurer) needs a sample of your urine or blood for testing to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form, you agree to submit a sample of urine and, if required, that blood may be drawn, testing may be done, and that the test result will be used in reaching an underwriting decision.

#### **Explanation of Test and the Meaning of the Test Result**

This is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been infected by the virus. If you submit a urine sample without a blood sample, the urine will be tested for HIV antibodies. If the urine test is reactive, the Insurer will require you to complete an HIV blood test in order for the Insurer to consider your eligibility for insurance. If you submit both blood and urine, the blood will be tested for HIV antibodies (not the urine).

The urine test is a screening test. A reactive urine HIV antibody screen should be followed by confirmation blood testing. The HIV antibody blood test is a three-step test procedure.

A positive blood test result does not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. A positive HIV blood test will mean that your application for insurance will be declined. An indeterminate test result may mean that you have been infected by the HIV virus or it may be due to a cause unrelated to the virus.

Other urine tests which may be performed include determinations and screening for liver or kidney disorder, diabetes, nicotine, certain prescription medications, and drugs of abuse (cocaine, heroin, etc.) Other blood tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver and kidney disorders and diabetes.

#### **Limitations of Test Results**

An HIV blood test will be considered positive only after confirmation by a laboratory procedure that has been determined to be highly accurate. Although rare, possible errors include:

- a. **False negatives:** The test gives a negative result even though you are infected with HIV. This happens only rarely, usually in recently infected persons. (It takes at least 4-12 weeks for a positive test result to develop after a person is infected.)
- b. **False positives:** The test gives a positive result, even though you are not infected. This is exceedingly rare and is more common in persons who have not engaged in high risk behavior.

**Confidentiality of Test Results**

The test result will be treated confidentially. The test result may be disclosed to:

1. employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer;
2. a reinsurer, if the reinsurer is involved in the underwriting process;
3. an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of a general code that also covers results of tests for other diseases or conditions not related to AIDS;
4. outside legal counsel who needs such information to effectively represent the Insurer in regard to your application, or as otherwise required by law;
5. persons preparing statistical reports that do not disclose identity.

**Report of Test Results**

If your test result is negative, no routine report will be made. If your test result is reported by the laboratory to the Insurer as being positive, reactive, or indeterminate resulting in an adverse underwriting decision, the result will be sent to a physician that you designate. You are asked to list below a physician of your choice so that this physician can tell you the test result and explain its meaning.

Physician to whom a possible positive, reactive or indeterminate test result will be reported:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

The result will be sent by registered mail with restricted delivery.

**Consent**

I have read and I understand the Notice and Consent for Urine or Blood Testing to Detect Infection by the AIDS Virus (HIV) (see other side of this form). I voluntarily consent to the withdrawal of blood from me, the testing of that blood if blood testing is required, and the reporting of the test result as described above. I also voluntarily submit a sample of my urine and consent to the testing of that urine and the reporting of the test result as described above. I also understand that the urine sample and, if required, the blood sample will be subject to further testing to provide additional information concerning my insurability. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date Signed