

STATEMENTS TO MEDICAL EXAMINER:
In continuation of and forming a part of application for insurance in



- American National Insurance Company
 American National Life Insurance Company of Texas

1. Proposed Insured's Last _____ Date of Birth (Mo-Day-Yr) _____ Sex: M F
 Name: First, M.I. _____

Name and address of your personal physician: (If none, so state)

Name: _____ Date last seen: _____
 Address: _____ Treatment given or medication prescribed: _____

2. To the best of your knowledge and belief have you ever been treated for or ever had any known indication of:
- | | | |
|--|--------------------------|--------------------------|
| 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 disorders; | <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 gall-bladder; | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of the kidney, bladder, prostate 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 the skin, lymph glands, cyst, tumor or cancer; | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorders of the blood; | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco, or any habit forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
3. Are you now under observation or taking treatment?
4. Have you had any change in weight in the past year?
5. Other than above, have you within the past 5 years:
- | | | |
|---|--------------------------|--------------------------|
| a. Had any mental or physical disorder not listed above; | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury, surgery; | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility; | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had an electrocardiogram, X-ray, other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?
9. Have you any knowledge or indication that you are not now in good health?
- If answered "Yes," explain in space at right.

Give full details below of all "Yes," answers to questions 2 through 9. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS: Include diagnosis dates, duration and names and addresses of all attending physicians and medical facilities)

	Age if Living?	Age at Death?	Cause of death?		Age if Living?	Age at Death?	Cause of Death
Father				Brothers and Sisters No. Living			
Mother				No. Dead			

I hereby declare that the statements to the medical examiner recorded above and all answers to the questions in this medical examination portion of my application for insurance are complete and true to the best of my knowledge and belief. I also agree that: (1) these statements and answers as written shall become the basis for and be included with and become part of any policy issued on these statements; and (2) the company is not bound by any statements made by anyone or any other facts known to anyone concerning any proposed insured(s) if not in writing in the application or in this statement to the medical examiner.

Signed at _____ this _____ day of _____

Signature of Witness

Signature of Proposed Insured

(To be completed and signed in presence of medical examiner.)

Form 8282



Rev. 6-03

EXAMINER'S VOUCHER
(Do not detach)

Medical Examiner _____

SS# or Tax I.D.#

NOTE: Specimen of urine to be forwarded to the Home Office whenever:

- Amount applied for is over \$75,000.
- Age 55 or above.
- There is history of Genito-Urinary Disease.
- There is elevated blood pressure.

Address of Examiner _____

Name of Person examined _____

Name of Agent _____ 1- _____

Agency 2- _____

Date of Examination _____

