



Statements to Medical Examiner (In continuation of and forming a part of application for insurance in)

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7999

American National Insurance Company (ANICO)
American National Life Insurance Company of Texas (ANTEX)



1. Proposed Insured's Name: Last, First, M.I. Date of Birth (Mo-Day-Yr) Sex: M F
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;
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorders;
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. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver, or gallbladder;
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of the kidney, bladder, prostate or reproductive organs;
g. AIDS (Acquired Immune Deficiency Syndrome) virus, ARC (AIDS Related Complex), or Immune Deficiency Disorder;
h. Diabetes; thyroid or other endocrine disorders;
i. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints;
j. Deformity, lameness or amputation;
k. Disorder of the skin, lymph glands, cyst, tumor or cancer;
l. Allergies; anemia or other disorders of the blood;
m. Excessive use of alcohol, tobacco, or any habit forming drugs?
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;
b. Had a checkup, consultation, illness, injury, surgery;
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility;
d. Had an electrocardiogram, X-ray, other diagnostic test?
6. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?
7. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?
8. 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 8. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS: Include diagnosis dates, duration and names and addresses of all attending physicians and medical facilities)

Table with columns: Age if Living?, Age At Death?, Cause of death?, Brothers and Sisters No. Living, No. Dead, Age if Living?, Age At Death?, Cause of Death. Rows for Father and Mother.

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 a 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.)



MEDICAL EXAMINER'S REPORT

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

9.	Height (In Shoes)		Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, At Umbilicus Relaxed	DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.)
	Ft.	In.	Lbs.	In.	In.	In.	

Did you weigh? Yes No Did you measure? Yes No
 Weight change in the past year _____ lbs. Gain Loss, Cause? _____
 Is appearance unhealthy or older than stated age? Yes No

10. BLOOD PRESSURE: All readings must be taken in a sitting position. If first reading is over 140/90 make two additional observations at 10 minute intervals.

	Rest	2nd	3rd
Systolic			
Diastolic (5th Phase)			

11. Pulse Rate:

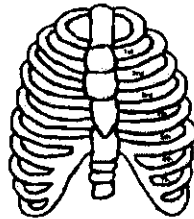
	Before Exercise	Immediately After	Three Minutes After
Pulse Rate			
Irregularities			

12. Heart:
- (a) Is there any evidence of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? Yes No
 - (b) Is there any history of Rheumatic fever?
 - (c) Is heart enlarged? (If yes, describe)
 - (d) Is murmur present? (If yes, complete 12e)
 - (e) Murmur is:

<input type="checkbox"/> Systolic	<input type="checkbox"/> Apical	<input type="checkbox"/> Soft (Gr. 1-2)
<input type="checkbox"/> Constant	<input type="checkbox"/> Basal	<input type="checkbox"/> Mod. (Gr. 3-4)
<input type="checkbox"/> Transmitted	<input type="checkbox"/> Presystolic	<input type="checkbox"/> Other
<input type="checkbox"/> Localized	<input type="checkbox"/> Diastolic	<input type="checkbox"/> Loud (Gr. 5-6)

 After exercise is murmur: Unchanged Increased Decreased Absent

- (f) If more than one murmur is present, explain under details at right.
 Show location of:
 Apex by X
 Area of murmur by ○
 Point of greatest intensity by ○
 Transmission by →



Your diagnosis of any cardiovascular abnormality _____

13. Is there on examination any abnormality of the following: Yes No
- (Circle applicable items and give details.)
- | | |
|---|--|
| (a) Eyes, ears, nose, mouth, pharynx, (if vision or hearing is markedly impaired, indicate degree and correction.) <input type="checkbox"/> <input type="checkbox"/> | (f) Genito-Urinary system (include prostate) <input type="checkbox"/> <input type="checkbox"/> |
| (b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins) <input type="checkbox"/> <input type="checkbox"/> | (g) Endocrine system (include thyroid and breasts) <input type="checkbox"/> <input type="checkbox"/> |
| (c) Nervous system (include reflexes, gait, paralysis) <input type="checkbox"/> <input type="checkbox"/> | (h) Musculoskeletal system (include spine, joints, amputations, deformities) <input type="checkbox"/> <input type="checkbox"/> |
| (d) Respiratory system <input type="checkbox"/> <input type="checkbox"/> | 14. Have you any pertinent information not found on examination or brought out in statements to medical examiner on reverse side? <input type="checkbox"/> <input type="checkbox"/> |
| (e) Abdomen (including scars or hernia) <input type="checkbox"/> <input type="checkbox"/> | 15. Are you related to the person examined or the Agent? <input type="checkbox"/> <input type="checkbox"/> |

16. URINALYSIS: (To be done in all cases.)
 Send specimen to laboratory in all cases. Specific Gravity: _____ Alb. _____ Sugar _____

I certify that I examined _____ at _____ A.M./P.M. on the _____ day of _____, _____

(Name of Applicant)
 Examination made at my office _____, Individual's office _____, Individual's home _____, other _____

Examiner's Signature: _____ Examiner's Address: _____

SS# [] [] [] or Tax I.D.# [] [] []



EXAMINER'S VOUCHER
(Do not detach)

**NOTE: Specimen of urine
to be forwarded to the Lab
in all cases.**

Medical Examiner _____

SS# or Tax I.D.#

Fee \$ _____

Address of Examiner _____

Name of Person examined _____

1- _____

Name of Agent _____ Agency 2- _____

Date of Examination _____