

**Daily Activities Questionnaire**

*American United Life Insurance Company\**  
a ONEAMERICA® financial partner  
One American Square, P.O. Box 6003  
Indianapolis, IN 46206-6003

*Pioneer Mutual Life Insurance Co.*  
A stock subsidiary of American United  
Mutual Insurance Holding Company  
a ONEAMERICA® financial partner  
101 North 10th Street  
Fargo, ND 58108



Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Do you engage in any type of exercise?  Yes  No  
If yes, please describe (What kind? Where? How frequently?) \_\_\_\_\_
2. Do you pursue any hobbies or other activities?  Yes  No  
If yes, please describe (What? How frequently?) \_\_\_\_\_
3. Do you work as a volunteer?  Yes  No  
If yes, please describe (What? How frequently?) \_\_\_\_\_
4. Have you fallen or been judged injured in the past three years?  Yes  No  
If yes, please give details: \_\_\_\_\_
5. In case of emergency, is there someone else in the household?  Yes  No  
If yes, please give details: \_\_\_\_\_
6. When did you last drive an automobile? \_\_\_\_\_  
In the past five years, have you had any driving violations or accidents?  Yes  No  
If yes, please give details: \_\_\_\_\_
7. Do you require assistance to perform daily living activities such as bathing, dressing, driving, shopping, walking or getting up and down?  Yes  No  
If yes, please give details: \_\_\_\_\_
8. Do you have a pet?  Yes  No What kind? \_\_\_\_\_
9. Do you ever use a cane, walker or wheelchair?  Yes  No  
If yes, what do you use and how often? \_\_\_\_\_
10. Do you manage your own finances?  Yes  No

I hereby represent that all of the above statements and answers to all of the above questions are complete and true, and I agree that they shall form part of the application and become part of any contract of insurance issued based on such application.

Signed at \_\_\_\_\_ this \_\_\_\_\_ of \_\_\_\_\_, \_\_\_\_\_  
City State Day Month Year

Witness

Signature of Proposed Insured

**Answers Made  
to Medical  
Examiner**

**AMERICAN UNITED LIFE  
INSURANCE COMPANY®**  
a ONEAMERICA® financial partner  
One American Square  
P.O. Box 368  
Indianapolis, IN 46206-0368

**PIONEER MUTUAL LIFE INSURANCE CO.**  
A stock subsidiary of American United  
Mutual Insurance Holding Company  
a ONEAMERICA® financial partner  
101 North 10th Street, P.O. Box 2546  
Fargo, ND 58108

**THE STATE LIFE  
INSURANCE COMPANY**  
a ONEAMERICA®  
financial partner  
P.O. Box 406  
Indianapolis, IN 46206



**Please print or type. Use black ink. Do not use dashes or ditto marks.**

Full Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ (SSN) \_\_\_\_\_

Name and Address of Personal Physician (If none, so state.) \_\_\_\_\_  
 \_\_\_\_\_  
 Date, reason and results for last doctor visit or consultation. \_\_\_\_\_

1. Is any person proposed for insurance now under observation, receiving treatment or taking medication prescribed by a member of the medical profession?  Yes  No

2. In the past 10 years (7 years in MD), has any person proposed for insurance ever been diagnosed as having, been treated for or ever had:

a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels?  Yes  No

b. Cancer, tumors, Kaposi sarcoma, disorder of the skin, swelling of the lymph glands, fever of unknown origin, night sweats, lupus or collagen disorder, arthritis or any bone or muscle disease?  Yes  No

c. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, nervous or mental disorder including anxiety, depression or attempted suicide?  Yes  No

d. Shortness of breath, persistent hoarseness or cough, blood spitting, pneumocystis carinii pneumonia, bronchitis, asthma, emphysema, tuberculosis, allergies, sleep apnea, or other chronic respiratory system disorder?  Yes  No

e. Diabetes, thyroid or other endocrine disorder, elevated blood sugar, albumin, blood, sugar or pus in the urine, stone or other disease of kidney, bladder, prostate or reproductive organs?  Yes  No

f. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of stomach, intestine, gallbladder or spleen?  Yes  No

g. Hepatitis, cirrhosis or disorder of the liver or pancreas?  Yes  No

h. Anemia, bleeding tendency or other disorder of the blood?  Yes  No

i. Disorder of eyes, ears, nose or throat?  Yes  No

j. Deformity, lameness or amputation?  Yes  No

k. Are you pregnant? If yes, due date \_\_\_\_\_  Yes  No

3. Has any person proposed for insurance within the past 5 years:

a. Had a checkup, consultation, illness, injury or surgery?  Yes  No

b. Had any diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study?  Yes  No

c. Been a patient in a hospital, clinic, sanitarium, or other medical facility?  Yes  No

d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed or where results are still pending or have a doctor's appointment scheduled?  Yes  No

e. Had any condition resulting in over 10 consecutive days of time lost from work?  Yes  No

f. Requested or received a pension, benefits or payment because of injury, sickness or disability?  Yes  No

Details of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS. (Include all dates, diagnoses, names and addresses of all attending physicians and medical facilities.)  
 (Enter additional details on page 2.)

Details of "Yes" answers continued:

4. Family History

	Age if still Living	Age at Death	State of Health/ Cause of Death	Cancer (all types)	Heart disease, stroke or circulatory disorder	Diabetes
Mother _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Siblings _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Nicotine Use:

a.  Never  Present  Former

b. Type of nicotine or tobacco used: \_\_\_\_\_

c. When did you quit using all forms of nicotine or tobacco/nicotine? (month/year) \_\_\_\_\_

6. Answer for the applicable state where the form is signed:

**Arizona, Connecticut, New Jersey, North Dakota or West Virginia:**

Has any person proposed for insurance been diagnosed or treated by a member of the medical profession as having AIDS?  Yes  No

**Wisconsin:**

Has any person proposed for insurance ever been diagnosed or treated for AIDS by a member of the medical profession, or had a positive test result confirming presence of the AIDS virus (HIV, HTLV-III)? (Test limited to FDA licensed blood tests for AIDS. Test performed at anonymous counseling and testing sites are confidential and should not be reported)  Yes  No

**Answer if state not listed above:**

Has any person proposed for insurance been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession, or had a positive test result confirming presence to the AIDS virus (Human Immunodeficiency Virus (HIV), Human T-cell Lymphotropic Virus - Type III (HTLV-III)?  Yes  No

I have read the statements and answers made above. They are, to the best of my knowledge and belief, true and complete and correctly recorded. This supplement will become a part of my application for insurance and will be a part of the basis of any insurance issued.

Signed at \_\_\_\_\_, on \_\_\_\_\_  
City State Date

Witness \_\_\_\_\_  
Signature of Medical Examiner Signature of Proposed Insured

**Medical Examiner's Report** (Paramedical Technician: Complete sections 1, 2, 4, 5, 6 and 7)  
(Physicians complete all sections.)

Answers must be in your handwriting. Please check appropriate column and record details under Question 6.

<p>1. a. Height ____ft. ____in. weight _____lbs. <i>Males only:</i> Chest (full inspiration) _____in. Chest (forced expiration) _____in. Abdomen (at umbilicus) _____in.</p> <p>b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Any change in weight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, loss _____lbs. / gain _____lbs.</p> <p>d. Reason for any change? _____</p>	<p>3. Do you find any evidence of past or present disease or abnormality of:</p> <p>a. Head and/or neck? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Lungs or chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Abdomen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Genito-urinary system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Extremities or peripheral vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Any other parts of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
<p>2. Cardiovascular Examination:</p> <p>a. Blood Pressure (sitting) – Please take 3 readings</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">1st</td> <td style="text-align: center;">2nd</td> <td style="text-align: center;">3rd</td> </tr> <tr> <td>Systolic</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Diastolic</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table> <p>b. Pulse Rate _____</p> <p>c. Irregularities _____</p> <p>d. Is the heart enlarged? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Is there a murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No TIMING: <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic INTENSITY: <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic</p> <p>f. In your opinion, would you describe the murmur as: <input type="checkbox"/> Functional <input type="checkbox"/> Organic</p>		1st	2nd	3rd	Systolic	_____	_____	_____	Diastolic	_____	_____	_____	<p>4. Are you aware of any additional medical history or obvious abnormalities concerning the proposed insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ _____</p> <p>5. Are you and the proposed insured related or are you and the proposed insured business or professional associates? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ _____</p> <p>6. DETAILS of "Yes" answers.(If you are the attending physician, please attach a copy of the patient's records.) _____ _____ _____ _____</p>
	1st	2nd	3rd										
Systolic	_____	_____	_____										
Diastolic	_____	_____	_____										
<p>7. How did you identify the Proposed insured? <input type="checkbox"/> Well known to you <input type="checkbox"/> Photo ID <input type="checkbox"/> Related (if related explain in #6)</p>													

TO THE MEDICAL EXAMINER: Any erasures or alterations in this report should be initialed by you. If you prefer to do so, you may send this report, or any information which you prefer not to include in this report, directly to the Medical Director of the Company, P.O. Box 6003, Indianapolis, IN 46206.

Signed at: \_\_\_\_\_ Date \_\_\_\_\_  
City State

Examination made at:  
 Office  Residence of:  Examiner  Proposed Insured at: \_\_\_\_\_  A.M.  P.M.

Signature of Examiner \_\_\_\_\_ Printed Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Paramedical Company: \_\_\_\_\_

If the Examiner is an M.D., name of Specialty: \_\_\_\_\_  
 Board Certified  Board Eligible