

Americo Financial Life and Annuity Insurance Company

Home Office: 500 N. Akard, P.O. Box 139040, Dallas, TX 75313-9040

Application Part II - Medical Questionnaire

Answers to be given by the Proposed Insured to the Medical Examiner

Please print all answers

Proposed Insured _____ Birth Date _____
 First Name Middle Initial Last Name Mo 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 within the past 10 years been treated for or had any known indication of:	Yes	No
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, venereal 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"/>
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 the above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had 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"/>
e. Been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you planning to consult a doctor for any physical or mental symptoms you have experienced within the past 60 days?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>
9. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>
	Age if Living?	Cause of Death?
Father		
Mother		
Brother and Sisters _____		
No. Living _____		
No. Dead _____		

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.

Agent's Name _____

I represent that the above statements and answers are true and complete to the best of my knowledge and belief, and I agree that such statements and answers shall be part of the application and are made to induce Americo Financial Life and Annuity Insurance Company to issue the policy or contract applied for. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, the MIB, Inc. or other organization institution or person that has any records or knowledge of me or my family members proposed for insurance, or our health, to give Americo Financial Life and Annuity Insurance Company or its reinsurers, any such information it may require to determine eligibility for insurance. A photographic copy of this original shall be as valid as the original.

Dated at _____ Signature of Proposed Insured _____
 Child's Parent if Proposed Insured is under age 16

on _____ Witness _____
 CA5010 (1/2001) Signature of Medical Examiner

MEDICAL QUESTIONNAIRE

10 a. 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? Yes No Did you measure? Yes No

c. Is appearance unhealthy or older than stated age? Yes No

11. Blood Pressure (Record ALL readings) Repeat B.P. if first over 135/85.

Systolic			
Diastolic	4th phase		
	5th phase		

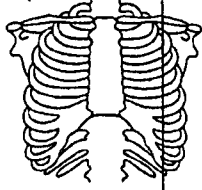
12. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13 a. Heart: Is there any:

Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No	Location		
Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema <input type="checkbox"/> Yes <input type="checkbox"/> No	Constant	<input type="checkbox"/>	<input type="checkbox"/>
(describe below - if more than one, describe separately)		Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
		Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
		Localized	<input type="checkbox"/>	<input type="checkbox"/>

b. Indicate:

Apex by	<input checked="" type="checkbox"/>				
Murmur area by	<input type="checkbox"/>		Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Point of greatest intensity by	<input type="checkbox"/>		Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Transmission by	<input type="checkbox"/>		Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>		Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>

13c. Your impression?

	After exercise:			
	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"/>	

14. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system? (include reflexes, gait, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen? (include scars)	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system? (include prostate)	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system? (include thyroid and breasts)	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system? (include spine, joints, amputations, deformities)	<input type="checkbox"/>	<input type="checkbox"/>

15. a. Are there any hernias? Yes No

 b. Any hemorrhoids? Yes No

16. Are you aware of additional medical history? Yes No

(A confidential report may be sent to the Medical Doctor)

Urinalysis	Specific Gravity	Albumin	Sugar	HOME OFFICE SPECIMEN REQUIRED - Mail to Home Office Reference Lab (CRL), P.O. Box 418991, Kansas City, MO 64179-0216
Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No				

I certify that I made this examination at: _____ A.M. P.M. on the day of _____, _____.

Examination made at my office, Individual's office, Individual's home, Other: _____

MEDICAL EXAMINER:

Please print name _____ Signature _____

Address _____ Medical School _____

_____ Date of Graduation _____ Yr. of Birth _____

THIS REPORT NOT TO BE GIVEN TO ANY COMPANY REPRESENTATIVE. MAIL DIRECTLY TO HOME OFFICE

**NOTICE AND CONSENT FOR BLOOD TESTING
WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

To determine your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood, saliva or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

COST OF TESTING

The cost of any testing will be borne by the insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact your designated physician, or you if you have not designated a physician. The insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Blood, Saliva or Urine Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the testing, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured

Date of Birth

Name and Address of Designated Physician:

Signature of Proposed Insured or Parent/Guardian

Date

State of Residence