

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 2. Height \_\_\_\_ ft. \_\_\_\_ in.      3. Weight \_\_\_\_\_ lbs.  
 If your weight has changed by over 10 lbs. in the last year, indicate amount and reason \_\_\_\_\_

**PHYSICIAN INFORMATION**

4. **Primary Physician**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_ Date last seen \_\_\_\_\_  
 Reason last seen and results of visit \_\_\_\_\_

5. **Physician Last Consulted**

Name \_\_\_\_\_ Specialty \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_ Date last seen \_\_\_\_\_  
 Reason last seen and results of visit \_\_\_\_\_

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes    No

**Family History: Include the age at onset/event for each medical condition.**

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

**MEDICAL HISTORY** - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

**Remarks - Explain All Yes Answers**  
 Enter question number before detailed response.

- Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:
7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?

**PART 2 - Medical History (continued)**

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes? .....	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts? .....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? .....			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles? .....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat? .....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the <b>last 5 years</b> , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed? .....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? .....	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

**PART 2 - Medical History (continued)**

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever: a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____ b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages? ..... c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?..... d. Attended or joined any organization due to alcohol or related problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently: a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?..... b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the <b>past 2 years</b> ? ..... If Yes, list in Remarks section at right.	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?.....	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application? ..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

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

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

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

**Instructions to the Examiner -**

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

1. Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in.  
 Weight (clothed) \_\_\_\_\_ lbs.

a. Did you weigh? Yes  No   
 b. Did you measure? Yes  No   
 If No, please explain \_\_\_\_\_

3. Blood Pressure (record 3 readings)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____

4. Pulse At rest \_\_\_\_\_  
 Describe any irregularities (number per minute, etc.)  
 \_\_\_\_\_

2. Measurements (males only)

Chest (full inspiration) \_\_\_\_\_ in.  
 Chest (forced expiration) \_\_\_\_\_ in.  
 Abdomen (at umbilicus) \_\_\_\_\_ in.

5. Are blood and urine specimens being collected and mailed to the lab? Yes  No

**IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 6 AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.**

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx? .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Stomach, abdominal organs? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Is the liver enlarged or tender? .....	<input type="checkbox"/>	<input type="checkbox"/>	
g. Genitourinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (including spine, joints, amputations and deformities)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.) .....	<input type="checkbox"/>	<input type="checkbox"/>	

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

**PART 3 - Medical Examiner's Report (continued)**

7. To be completed if number 6.i. is answered Yes or if requested:		Yes	No	Remarks
a.	Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b.	Are there any abnormalities of the first (S1) or second (S2) heart sounds?.....	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Are there gallops (S3 or S4)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
d.	Is/are there ejection sound(s) or systolic click(s)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e.	Is/are there murmur(s) present?..... If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	<input type="checkbox"/>	<input type="checkbox"/>	
8. a.	Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b.	Does the Proposed Insured appear in any way unhealthy or older than the stated age?.....	<input type="checkbox"/>	<input type="checkbox"/>	
9. a.	Were you acquainted with the Proposed Insured prior to this examination?..... If Yes, fully describe the relationship in Remarks.	<input type="checkbox"/>	<input type="checkbox"/>	
b.	Are you the Proposed Insured's personal physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Was the examination conducted in a language other than English?..... If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.	<input type="checkbox"/>	<input type="checkbox"/>	
d.	Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured?.....	<input type="checkbox"/>	<input type="checkbox"/>	
10. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other _____				
Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.				

I hereby certify that I have personally examined \_\_\_\_\_ and have correctly and fully reported my findings. Name of Proposed Insured

Examined at \_\_\_\_\_  
Street address, City and State

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ AM/PM.

Print Examiner's name \_\_\_\_\_ Signature of Examiner \_\_\_\_\_  
 Paramed     MD     D.O.

Paramed Company \_\_\_\_\_ Telephone number \_\_\_\_\_

Address \_\_\_\_\_



1701 Research Boulevard  
Rockville, Maryland 20850  
(301) 279-4800

**NOTICE AND CONSENT FOR BLOOD TESTING  
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

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

Unless precluded by law, tests may be performed 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All tests 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. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. The names of these organizations will be disclosed to you upon written request. 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.

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 you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. 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.

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 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.

In the event of a positive test result, I authorize the insurer to send the results to one of the following:

- Send the results directly to me at the residence address shown on the application or the address as shown below:

\_\_\_\_\_  
Alternate Address

- Send the results to the physician shown below:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Address

In either case the result will be sent to the appropriate person by registered mail with restricted delivery.

If you fail to designate a physician to whom a positive test result should be sent, you may obtain personal, face-to-face counseling through the Virginia Department of Health. To obtain information regarding counseling, you should contact your local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Virginia Health Department at 1-800-533-4148.

A negative test result will be sent to you if you so desire. Indicate below if you wish this to be done.

- Send a negative test result to me at the residence address shown on the application or the address as shown below:

\_\_\_\_\_  
Alternate Address

- Do not send a negative test result to me.

I have read and I understand this Notice of Consent For Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, 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

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence



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Rockville, Maryland 20850  
(301) 279-4800

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\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence