

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.

Yes No **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? Yes No
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? Yes No
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?..... Yes No

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 last 5 years , 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 past 2 years ?..... 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	_____	_____	_____

2. Measurements (males only)
- Chest (full inspiration) _____ in.
 Chest (forced expiration) _____ in.
 Abdomen (at umbilicus) _____ in.

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

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)

	Yes	No	Remarks
7. To be completed if number 6.i. is answered Yes or if requested:			
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

**INFORMATION STATEMENT
for HIV Antibody Testing Consent Form**

The insurance company to which you have applied may request a blood sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The result of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" of your blood to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other blood abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-872-8909.

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be send to your private physician so that he can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or entity: Name: _____
Address: _____

Informed Consent

I have read and understand this information. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure or the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured

Birthdate

State of Residence

Date Signed by Proposed Insured

Signature of Witness