

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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	

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"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <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"/> <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.

<p>1. Height (in shoes) _____ ft. _____ in. Weight (clothed) _____ lbs.</p> <p>a. Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/> b. Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, please explain _____ _____</p> <p>2. Measurements (males only) Chest (full inspiration) _____ in. Chest (forced expiration) _____ in. Abdomen (at umbilicus) _____ in.</p>	<p>3. Blood Pressure (record 3 readings)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Systolic</td> <td style="width: 50px;"></td> <td style="width: 50px;"></td> <td style="width: 50px;"></td> </tr> <tr> <td style="padding: 2px;">Diastolic</td> <td></td> <td></td> <td></td> </tr> </table> <p>4. Pulse At rest _____ Describe any irregularities (number per minute, etc.) _____ _____</p> <p>5. Are blood and urine specimens being collected and mailed to the lab? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Systolic				Diastolic			
Systolic									
Diastolic									

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

INFORMATION STATEMENT for Human Immunodeficiency Virus (HIV) Related Tests

Vermont law requires that the agent read this entire statement to you aloud, subject to penalties to the agent and the Insurer.

To determine your insurability, the Insurer may request a sample of your blood for testing and analysis. One of the tests will be to determine the presence or absence of antibodies to the HIV Virus. HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome).

The test is actually a three-step test protocol. If the blood sample is reactive within specific limits, then it is considered positive for the HIV antibody.

While positive HIV antibody test results would not mean that you have AIDS, they would mean that you would be at seriously increased risk of developing AIDS or AIDS-related conditions. Presence of antibodies in blood means that the person has been infected with the HIV virus. It is still possible that the person will not develop AIDS or AIDS-related conditions.

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. Absence of HIV antibodies does not mean that you are immune to the virus.

You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. Public health officials recommend that persons who test positive for the HIV antibodies should seek counseling to become informed about the implications of the test results.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you should consult your own physician or own health care provider.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The results also may be reported to its affiliates, reinsurers, medical personnel, laboratories, and insurance support organizations in connection with insurance for which you have applied. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific blood abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you.

An individual damaged by unauthorized disclosure can sue for relief, and may recover attorney fees and court costs.

The Insurer will pay for this test. Neither you nor your health care provider will be billed. If you decide to consult with someone before consenting to this test, that delay will not in and of itself affect the status of any application or policy, nor extend the term of any binding receipt.

If a test is indeterminate, you may request in writing to be retested after 6 but not later than 8 months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any underwriting decision granting a substandard classification or exclusion based on your prior HIV-related test results will be reversed.

If you are denied insurance because you tested positive, you may request, once within three years, in writing, that the insurer retest you. If a new test is approved by the Vermont Insurance Commissioner, you may also request retesting. If the retest is negative, the Insurer may not deny you coverage based on the initial test.

You will be asked for your written informed consent before blood is drawn. You will also be asked to give the name and address of a physician or other person to whom test results may be sent.

**ACKNOWLEDGMENT AND CONSENT
FOR HIV-RELATED TESTS**

I have listened to the undersigned agent read aloud this printed information statement to me. I acknowledge that I have heard and understood this material, and that I have received a copy of this information statement.

Name of Agent	Name of Proposed Insured
Signature of Agent	
Date	Signature of Proposed Insured or Parent/Guardian

NOTIFICATION OF TEST RESULTS

If your test results are positive or indeterminate, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer may report the test results and who may explain their meaning.

Physician or other person to whom positive or indeterminate test results may be reported:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

If your test results are negative, we will send the results to you unless you ask us to send them to the physician or other person named above by checking here:

INFORMED CONSENT

I have read and I understand this Information Statement for HIV-Related Tests, Notification of Test Results, and Informed Consent form. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

Name of Proposed Insured	Signature of Proposed Insured	Date
Birthdate	State of Residence	
Medical Professional Drawing Blood		



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Rockville, Maryland 20850

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You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. Public health officials recommend that persons who test positive for the HIV antibodies should seek counseling to become informed about the implications of the test results.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you should consult your own physician or own health care provider.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The results also may be reported to its affiliates, reinsurers, medical personnel, laboratories, and insurance support organizations in connection with insurance for which you have applied. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific blood abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you.

An individual damaged by unauthorized disclosure can sue for relief, and may recover attorney fees and court costs.

The Insurer will pay for this test. Neither you nor your health care provider will be billed. If you decide to consult with someone before consenting to this test, that delay will not in and of itself affect the status of any application or policy, nor extend the term of any binding receipt.

If a test is indeterminate, you may request in writing to be retested after 6 but not later than 8 months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any underwriting decision granting a substandard classification or exclusion based on your prior HIV-related test results will be reversed.

If you are denied insurance because you tested positive, you may request, once within three years, in writing, that the insurer retest you. If a new test is approved by the Vermont Insurance Commissioner, you may also request retesting. If the retest is negative, the Insurer may not deny you coverage based on the initial test.

You will be asked for your written informed consent before blood is drawn. You will also be asked to give the name and address of a physician or other person to whom test results may be sent.

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FOR HIV-RELATED TESTS**

I have listened to the undersigned agent read aloud this printed information statement to me. I acknowledge that I have heard and understood this material, and that I have received a copy of this information statement.

Name of Agent	Name of Proposed Insured
Signature of Agent	
Date	Signature of Proposed Insured or Parent/Guardian

NOTIFICATION OF TEST RESULTS

If your test results are positive or indeterminate, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer may report the test results and who may explain their meaning.

Physician or other person to whom positive or indeterminate test results may be reported:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

If your test results are negative, we will send the results to you unless you ask us to send them to the physician or other person named above by checking here:

INFORMED CONSENT

I have read and I understand this Information Statement for HIV-Related Tests, Notification of Test Results, and Informed Consent form. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

Name of Proposed Insured	Signature of Proposed Insured	Date
Birthdate	State of Residence	
Medical Professional Drawing Blood		