

Proposed Insured's Name (First, M.I., Last)	Date of Birth	Social Security Number
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All questions pertain to proposed insured unless otherwise indicated.  
All YES answers require full details.

1. Do you have a personal physician? (If YES, complete the following.) ..... Yes  No

Name, Address and Telephone Number of Personal Physician	Date last visited, reason, results
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2. Have you had any weight gain or loss in the last year? (If YES, complete the following.) ..... Yes  No

Weight Gain (lbs.)	Weight Loss (lbs.)	Reason for Gain or Loss
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3. Within the past 10 years, have you been treated or diagnosed by a member of the medical profession as having: (If YES, circle applicable condition.)

- a. Nervous or mental disorder, paralysis, epilepsy, loss of consciousness, stroke, recurring dizziness, or chronic headaches? ..... Yes  No
- b. Asthma, pleurisy, bronchitis, emphysema, tuberculosis, spitting blood, or chronic cough? ..... Yes  No
- c. Heart attack, heart disease, palpitations, angina or pain in the chest, heart murmur, rheumatic fever, or high blood pressure? ..... Yes  No
- d. Ulcer of stomach or duodenum, colitis, disease of liver or gall bladder, or gallstones? ..... Yes  No
- e. Kidney disease, kidney stone, or renal colic? ..... Yes  No
- f. Blood, albumin, sugar or pus in the urine? ..... Yes  No
- g. Diabetes, venereal disease, goiter, or hernia? ..... Yes  No
- h. Anemia, or any disease of the blood or lymph glands? ..... Yes  No
- i. Eye or ear disease, loss of sight or hearing? ..... Yes  No
- j. Any disease of the breasts or pelvic organs? ..... Yes  No
- k. Any bone or joint disease, arthritis, gout, backache, sciatica, loss of extremity or deformity? ..... Yes  No
- l. Any thyroid or other endocrine disorder? ..... Yes  No
- m. Any cyst, cancer or tumor? ..... Yes  No
- n. Any immune deficiency disorder, AIDS, or AIDS Related Complex (ARC) or positive test results indicating the presence of the AIDS virus? ..... Yes  No
- o. Any other illness, disease or injury? ..... Yes  No

4. Within the past 10 years, have you:

- a. Had any treatment for, or been advised to have treatment for or to refrain from, the use of alcohol or any drug? ..... Yes  No
- b. Used amphetamines, barbiturates, cocaine, heroin, sedatives or any controlled substance not prescribed by a physician? ..... Yes  No
- c. Had or been advised to have any surgery? ..... Yes  No
- d. Been treated or been advised to have treatment in or at any hospital, clinic or similar institution? ..... Yes  No

5. Within the past 5 years, have you:

- a. Had a physical examination? ..... Yes  No
- b. Had any X-rays, electrocardiograms, blood tests or any other medical tests? ..... Yes  No
- c. Taken any medication? ..... Yes  No
- d. Been disabled? ..... Yes  No

6. Are you:

- a. Now being treated by a physician or other licensed medical practitioner? ..... Yes  No
- b. Now pregnant? (If YES, expected date of delivery \_\_\_\_\_) ..... Yes  No

7. Has any immediate family member had any history of cancer, high blood pressure, heart or kidney disease, tuberculosis, epilepsy, diabetes, mental illness or attempted suicide? ..... Yes  No



**Medical Examiner's Report**

Part III of Application to

Banner Life Insurance Company

1701 Research Blvd., Rockville, MD 20850-3191

9. a.	Height (In Shoes) ft. in.  (cm.)	Weight (Clothed) lbs.  (kgs.)	Chest (Full Inspiration) in.  (cm.)	Chest (Forced Expiration) in.  (cm.)	Abdomen, (at Umbilicus) in.  (cm.)
	b. Did you weigh?	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	c. Did you measure?	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	d. Is appearance unhealthy or older than stated age?	Yes <input type="checkbox"/> No <input type="checkbox"/>			

10. Blood Pressure (Record ALL readings):

Systolic			
Diastolic			

11. Pulse:

	At rest	After exercise	3 minutes later
Rate			
Irregularities per min.			

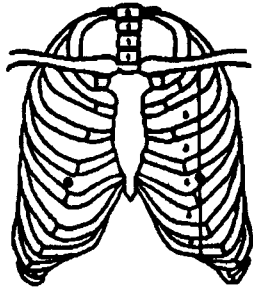
12. Heart:

Any enlargement? Yes  No  Any murmurs? Yes  No

Any dyspnea? Yes  No  Any edema? Yes  No

Indicate:  X  
 O  
 □  
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Location	First Murmur	Second Murmur	Apex by	Point of greatest intensity by	Transmission by
Constant	<input type="checkbox"/>	<input type="checkbox"/>			
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>			
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>			
Localized	<input type="checkbox"/>	<input type="checkbox"/>			
Systolic	<input type="checkbox"/>	<input type="checkbox"/>			
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>			
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>			
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>			
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>			
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>			
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"/>			



c. Nervous system (include reflexes, gait and paralysis)? Yes  No

d. Respiratory system? Yes  No

e. Abdomen (describe scars)? Yes  No

f. Genitourinary system (include prostate)? Yes  No

g. Endocrine system (include thyroid and breasts)? Yes  No

h. Musculoskeletal system (include spine, joints, amputations and deformities)? Yes  No

14. a. Any hernias? Yes  No

b. Any hemorrhoids? Yes  No

15. Are you aware of any additional information which may have a bearing on the risk? Yes  No

(If YES, see reverse side; or a confidential report may be sent to the medical director.)

16. Urine (Collect another specimen if less than 1.012):

Urinalysis: Specific Gravity	Albumin	Sugar

Send specimen to lab in pre-addressed postage-paid envelope, or if blood profile being drawn, use container in blood kit.

Is blood profile being sent to lab? Yes  No

Is specimen being sent to lab? Yes  No

Details in connection with questions 9d, 12, 13, 14 and 15 answered YES. (Identify question number and complete details on the reverse of this form.)

Name of person requesting this examination? \_\_\_\_\_

Examined at (check one):

Proposed Insured's residence  Examiner's office

Proposed Insured's business

Date Examined \_\_\_\_\_ 20\_\_\_\_ Time \_\_\_\_\_ A.M.  
P.M.

X \_\_\_\_\_

Medical Examiner Signature

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_

State comments and your impression in DETAILS space.

13. On examination is there any abnormality of the following:

a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) Yes  No

b. Skin (include scars), lymph nodes, veins or peripheral arteries? Yes  No

**VOUCHER**

Fee \$25.00

Proposed Insured's Name (First, M.I., Last)	Agent's Name
Medical Examiner's Name	Medical Examiner's Address (Street, City, State, Zip)
Date of Examination (month/day/year)	Social Security or Tax ID No.

For Completion by Company

Date Paid \_\_\_\_\_

Check No. \_\_\_\_\_

PLEASE MAIL PROMPTLY TO: BANNER LIFE INSURANCE COMPANY  
 1701 Research Boulevard  
 Rockville, Maryland 20850

Check in payment of fees will be mailed promptly by the company. No agent is authorized to pay you for this examination.

Part II (Continued)

(All questions pertain to proposed insured unless otherwise indicated.)

Details in connection with questions 3-7. (Attach Additional Details Supplement to Application if more space needed.):

Question No.	Give full details for each question answered YES, including date, nature of illness or injury, number of attacks, duration, severity, treatment, results, name, address and telephone number of doctors, hospitals or clinics involved.

8. Family History:	If Living		If Deceased		
	Name of Family Member	Age	State of Health	Age	Cause of Death
	Father				
	Mother				
	Brothers				
	Sisters				

To the best of my knowledge and belief, the answers recorded herein are true and complete.

(Please DO NOT Use Felt Tip Pen for Signatures.)

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City State Zip Date (month/day/year)

Proposed Insured (or parent or legal guardian if Proposed Insured is a minor)  Medical Examiner

**AUTHORIZATION.** I authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, employer, consumer reporting agency, the Medical Information Bureau, and any other organization, institution or person having any information (including diagnosis, treatment or prognosis) about my physical or mental condition or any other information about me or my health, to give to Banner Life Insurance Company, its authorized representatives and its reinsurers any such information. I understand that this information will be used by Banner Life Insurance Company or its reinsurers to determine my eligibility for insurance or my eligibility for benefits under an insurance policy.

This authorization shall be valid for 30 months from the date below. A photostatic copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City State Zip Date (month/day/year)

Proposed Insured (or parent or legal guardian if Proposed Insured is a minor)  Medical Examiner

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Record any additional medical information here. It will be considered strictly confidential. Anything regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated.

X \_\_\_\_\_  
Medical Examiner Signature

X \_\_\_\_\_  
Date (month/day/year)

Print Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone # ( ) \_\_\_\_\_  
\_\_\_\_\_