



**BENEFICIAL LIFE INSURANCE COMPANY**  
**Paramedical / Medical Examination**

**Check Purpose:**    New Insurance    Change    Add Benefit    Reconsideration    Reinstatement

Proposed Insured's Name \_\_\_\_\_ Social Sec. Number \_\_\_\_\_  
 Gender:    Male    Female   Drivers License # \_\_\_\_\_ State \_\_\_\_\_  
 Amount Applied for: \$ \_\_\_\_\_ Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Agent Requesting Exam \_\_\_\_\_ Agency Name \_\_\_\_\_

**Paramedical Interview Questions**

Each question must be individually asked and answered. Give details of "Yes" answers below: 1) Identify question number. 2) State signs, symptoms and diagnosis of each illness or injury. 3) List the details and results of any treatment. 4) List the name, full address and dates of each health care provider consulted in the space provided on page 3.

**Details**

1. Have you ever been treated for or ever had any known indication of:	Yes	No
a. Disorder of eyes ( <i>including double vision</i> ), ears, nose, mouth, throat, or speech?	Yes	No
b. Dizziness, loss of balance, headaches, seizures or convulsions, muscle weakness, tremor, paralysis, stroke, memory loss, or any disease of the brain or nervous system?	Yes	No
c. Anxiety, depression, stress, or any psychological or emotional condition or disorder?	Yes	No
d. Persistent shortness of breath, hoarseness, cough, coughing up blood, asthma, emphysema, tuberculosis or any lung or respiratory disorder?	Yes	No
e. Jaundice, hepatitis, intestinal bleeding, ulcer, hernia, chronic diarrhea, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver, gall bladder, or pancreas?	Yes	No
f. High blood pressure, chest pain, chest discomfort, chest tightness, irregular heart beat, heart murmur, heart attack, or any disorder of the heart or blood vessels?	Yes	No
g. Sugar, albumin, blood or pus in the urine, sexually transmitted or venereal disease, except HIV, or any disorder of the kidney, bladder, prostate, or reproductive organs?	Yes	No
h. Diabetes, thyroid or any glandular ( <i>endocrine</i> ) disorder?	Yes	No
i. Cancer, tumor, polyp, or disorder of the lymph gland(s) or breast(s)?	Yes	No
j. Anemia, bleeding tendency, or any disorder of the blood, except HIV?	Yes	No
k. Arthritis, sciatica, gout, or any disorder of the muscles, bones, joints, spine, back or neck?	Yes	No
l. Chronic or unexplained fatigue, fever, or illness?	Yes	No
m. Any allergies?	Yes	No
n. Any disorders of the skin?	Yes	No
o. Deformity, lameness or amputation?	Yes	No

**Beneficial Life Paramedical Interview, continued**

**Details**

<b>2. Other than as previously stated, in the last five years have you:</b>		
a. Consulted any other health care providers ( <i>medical doctor, psychiatrist, psychologist, chiropractor, counselor, therapist, or other</i> )?	Yes	No
b. Been a patient in a hospital, clinic, or medical facility?	Yes	No
c. Had any diagnostic studies ( <i>EKG, x-ray, blood tests, or any other</i> )?	Yes	No
d. Had surgery?	Yes	No
e. Been advised to have any test, consultation, hospitalization, or surgery that was not completed?	Yes	No
<b>3. Do you now have an appointment scheduled with a care provider or treatment facility, or do you intend to schedule an appointment with a care provider or treatment facility within the next 3 months?</b>	Yes	No
<b>4a. Have you ever tested positive for HIV antibodies as part of a test for obtaining insurance?</b>	Yes	No
b. Have you ever been told by a medical professional that you have AIDS?	Yes	No
<b>5. Are you taking medication or drugs (legal or illegal, prescription or nonprescription) for any reason? If yes, list medications and/or drugs.</b>	Yes	No
<b>6a. Have you ever been advised to limit the use of alcohol or drugs, sought or received treatment, advice, or counseling for alcohol or drugs, or joined a group because of alcohol or drug use?</b>	Yes	No
b. In the last 10 years, have you used marijuana, cocaine, heroin, amphetamines, or hallucinogens?	Yes	No
c. In the last 10 years, have you used any tranquilizers, sedatives, or narcotic drugs?	Yes	No
d. In the last 10 years, have you used legally prescribed drugs in excess of dosages prescribed by physician or medical practitioner?	Yes	No
<b>7a. Do you currently drink alcohol?</b> If yes, type and frequency per week?	Yes	No
b. Have you ever used alcohol? If yes, date last used: _____ Reason quit: _____	Yes	No
<b>8. Have you lost weight in the last 6 months?</b> If yes, loss was _____ pounds. Give reason for loss.	Yes	No
<b>9. Have you used tobacco or nicotine in any form in the last 10 years?</b> If yes, indicate type, <input type="checkbox"/> Cigarette, pipe, snuff, chewing tobacco, nicotine gum nicotine patch, or other form of nicotine. Date last used _____ <input type="checkbox"/> Cigar. Date last used _____ Frequency of use _____	Yes	No
<b>10. Do you have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide, or any hereditary disease?</b>	Yes	No
<b>11a. During the last 6 months have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury?</b>	Yes	No
b. Within the last 5 years have you requested or received disability payments or benefits because of an injury, accident, or sickness?	Yes	No

**Beneficial Life Paramedical Interview, continued**

**Physicians Related to "Yes" Responses on Page 2** *(Attach additional pages as needed.)*

**Question #** \_\_\_\_\_ **Insured Name** \_\_\_\_\_ **Explain condition nature, severity, frequency and medication** \_\_\_\_\_

**Onset Mo. Year** \_\_\_\_\_ **Date and extent of recovery** \_\_\_\_\_ **Doctor's Name** \_\_\_\_\_ **Doctor's Phone #** \_\_\_\_\_

\_\_\_\_\_  
Doctor's Address

**Question #** \_\_\_\_\_ **Insured Name** \_\_\_\_\_ **Explain condition nature, severity, frequency and medication** \_\_\_\_\_

**Onset Mo. Year** \_\_\_\_\_ **Date and extent of recovery** \_\_\_\_\_ **Doctor's Name** \_\_\_\_\_ **Doctor's Phone #** \_\_\_\_\_

\_\_\_\_\_  
Doctor's Address

**Question #** \_\_\_\_\_ **Insured Name** \_\_\_\_\_ **Explain condition nature, severity, frequency and medication** \_\_\_\_\_

**Onset Mo. Year** \_\_\_\_\_ **Date and extent of recovery** \_\_\_\_\_ **Doctor's Name** \_\_\_\_\_ **Doctor's Phone #** \_\_\_\_\_

\_\_\_\_\_  
Doctor's Address

**12. Family History** Please list all immediate family members by relation to insured, age and medical history.

	<b>Age if Living</b>	<b>Medical History or Cause of Death</b>	<b>Age at Death</b>
Father			
Mother			
Brothers or Sisters			

**13. Who is your regular or personal physician, doctor, or health care provider?**  None

**Doctor's Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Address** \_\_\_\_\_

**Date last seen:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

**Authorization**

I represent that the statements and answers given above are true, complete and correctly recorded, to the best of my knowledge and belief. I hereby expressly authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other insurance support organizations, that has any records or knowledge of me or my family or of our health to give any such information to the Beneficial Life Insurance Company and its reinsurers. This authorization will be valid no longer than 6 months from the date the authorization is signed. Upon request, a copy of this authorization will be provided to you. A photographic copy of this authorization shall be as valid as the original.

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

\_\_\_\_\_  
Dated

\*If proposed insured is under 14 years and 6 months, parent or legal guardian must sign.



## This Page to be Completed as Part of M.D. Examinations Only

**14. Heart, Is there any:**

- Enlargement     Yes    No  
 Murmur         Yes    No  
 Edema          Yes    No  
 Dyspnea       Yes    No  
 Other          Yes    No

	Murmur # 1	Murmur # 2
Location		
Grade		
Area of Transmission		
Quality		

**15. Blood Pressure**

Systolic        \_\_\_\_\_  
 Holosystolic    \_\_\_\_\_  
 Diastolic        \_\_\_\_\_

Increased with Exercise     Yes     No

<b>16. On examination, is there any abnormality of the following:</b> <i>(Circle applicable and give details)</i>		
a. Eyes, ears, nose, mouth, pharynx?	Yes	No
b. Skin <i>(including scars)</i> , lymph nodes, varicose veins or peripheral arteries?	Yes	No
c. Nervous system <i>(include reflexes, gait, paralysis)?</i>	Yes	No
d. Respiratory system?	Yes	No
e. Abdomen <i>(include scars)?</i>	Yes	No
f. Genitourinary system <i>(include prostate)?</i>	Yes	No
g. Endocrine system <i>(include thyroid and breasts)?</i>	Yes	No
h. Musculoskeletal system <i>(include spine, joints, amputations, deformities)?</i>	Yes	No

**Comments:**

**Doctor Certification:** I certify that the above is a record of a careful examination of the insured and that I completely and correctly recorded the answers on the questionnaire before it was signed by the proposed insured.

Examination was made at: \_\_\_\_\_  
Day & Date
Time
Location

Doctor Phone Number \_\_\_\_\_ Doctor Address \_\_\_\_\_

Doctor Name *(printed)* \_\_\_\_\_ Doctor Signature \_\_\_\_\_



## BENEFICIAL LIFE INSURANCE COMPANY

### Notice And Consent For AIDS-Related Blood Testing

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that the underwriting decisions will be based on the test result. The costs of all HIV antibody testing will be covered by the insurer. An enzyme-linked immunosorbent assay serologic (ELISA) test, which has been licensed by the federal Food and Drug Administration to detect antibodies to the HIV virus, will be performed. If this test result is positive, a second ELISA will test will be performed. If the second test result is positive, a third ELISA test will be performed. If the third ELISA test result is positive, a confirmatory Western Blot Assay test will be performed, which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the HIV virus.

#### Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your own expense, prior to being tested.

#### Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city may provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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 Result

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. If you have had a positive ELISA test result or a positive Western Blot Assay or both, your test results may be released to an insurance support organization or another insurer using a nonspecific test result code that does not indicate that you were subject to testing related to the human immunodeficiency virus.

#### Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will be notified. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you may choose to have your test results forwarded to a private physician or your county health department. Please designate the party or parties to receive notification of your test results (you may designate more than one).

\_\_\_ Applicant

\_\_\_ Private Physician

Name

Address

\_\_\_ County Health Department

Name

Address

#### Consent

I have read and I understand this Notice and consent for AIDS-related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of blood, and the disclosure of the test results as described above. I have read the information on this form about what a positive test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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. This consent authorization is limited to six months from the date of signature.

Signature of Proposed Insured or Parent/Guardian

Date Signed

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

Address: \_\_\_\_\_



## BENEFICIAL LIFE INSURANCE COMPANY

# HIV Antibody Test Information for Insurance Applicant

### AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and others having sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 – 50% chance of developing AIDS over the next 10 years.

## The HIV Antibody Test

Before consenting to testing, please read the following important information:

1. **Purpose** – An enzyme-linked immunosorbent assay serologic (ELISA) test, which has been licensed by the federal Food and Drug Administration to detect antibodies to the HIV virus, will be performed. If this test result is positive, a second ELISA test will be performed. If the second test result is positive, a third ELISA test will be performed. If the third test result is positive, a confirmatory Western Blot Assay test will be performed, which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the HIV virus. These tests are being run to determine whether you may have been infected with HIV. If you are infected you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results** – If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.
3. **Accuracy** – An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
  - a. **False Positives** – This test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Re-testing should be done to help confirm the validity of a positive test.
  - b. **False Negatives** – The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 – 12 weeks for a positive test result to develop after a person is infected.
4. **Possible Adverse Effects of Test** – A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results** – A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you directly, or through your physician, or the county health department.
6. **Confidentiality** – Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, if you have had a positive ELISA test result or a positive Western Blot Assay or both, your test results may be provided to an insurance support organization or another insurer using a nonspecific test result code that does not indicate that you were subject to testing related to the human immunodeficiency virus. Your insurance agent will provide you with additional written information about this subject at your request.
7. **Prevention** – Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information** – Further information about HIV testing and AIDS can be obtained by calling the California AIDS hotline in Northern California at 1-800-367-AIDS and in Southern California at 1-800-922-AIDS.



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**BENEFICIAL LIFE INSURANCE COMPANY****HIV Test Counseling Resources List**

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to the Insurer named above. Therefore, the Insurer makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Insurer makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. If you need further information, we suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross.

**AIDS HOTLINE**

U.S. Public Health Service  
(800) 342-AIDS

**SPANISH AIDS HOTLINE**

(800) 222-AIDS

**CALIFORNIA HIV/AIDS HOTLINE**

(800) 367-2437 or  
(415) 863-2437

**AIDS HOTLINE – SOUTHERN CALIFORNIA**

(800) 922-AIDS

**CALIFORNIA DEPT. OF HEALTH SERVICES**

Statewide Services – Office of AIDS  
(916) 449-5900  
Sacramento

**SAN JOAQUIN AIDS FOUNDATION**

(209) 476-8533  
Stockton

**INLAND EMPIRE AIDS COORDINATION AND EDUCATION PROJECT**

(714) 825-7510  
Riverside

**AIDS PROJECT, HEMOPHILIA COUNCIL**

(714) 834-2604  
Santa Ana