

**APPLICATION FOR INSURANCE TO
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
(PART 2-MEDICAL)**

Representations to the Medical Examiner

This application is to be attached to and made part of the policy.

Proposed Insured: _____ Birth Date: _____
(Please print) First Name M.I. Last Name

1a. Name and address of your personal physician (If none, so state)

b. Date and reason last consulted? _____

c. What treatment or medication was given or recommended?

If you answer **yes** to questions 2-14, provide details in Item #15 on the next page.

2. Have you ever had or been treated for cancer or tumor? Yes No
3. In the last ten years, have you had, been treated for or received counseling for:
- a. high blood pressure, chest pain or disorder of the heart or circulatory system? Yes No
 - b. diabetes or disorder of the glands, bone, blood or skin? Yes No
 - c. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? Yes No
 - d. hernia, hepatitis or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum? Yes No
 - e. arthritis, rheumatism, or disorder of the joints, limbs or muscles? Yes No
 - f. disorder or condition of the back, neck or spine? Yes No
 - g. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? Yes No
 - h. epilepsy, stroke, dizziness, headache, or disorder of the brain, or spinal cord? Yes No
 - i. disorder of the eyes, ears, nose or throat? Yes No
 - j. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? Yes No
 - k. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme Disease? Yes No
4. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? Yes No
5. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus? Yes No
6. a. Are you currently taking prescribed medication? Yes No
- b. Are you currently taking non-prescription medication? Yes No
7. a. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance other than as prescribed by a physician? Yes No
- b. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? Yes No
8. Are you now pregnant? *If yes, expected delivery date:* _____ Yes No
9. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? Yes No

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

A. How long have you known Proposed Insured? _____

	Yes	No
1. Has Proposed Insured ever been your patient? If "yes," are details included in history given?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you related to Proposed Insured or Agent?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you examining Proposed Insured concurrently for another company?	<input type="checkbox"/>	<input type="checkbox"/>

B. Build

1. Height (in Shoes) ft. in.	Weight (Clothed) lbs.	Males Only		
		Chest Full Inspiration in.	Chest Forced Expiration in.	Abdomen or Umbilicus in.

2. Did you weigh? Yes No
Did you measure? Yes No

C. Pulse

	Rate	Number of Irregularities
At rest		
Immediately after exercise		
Two minutes after exercise		

D. Blood Pressure (if above 140/90 record additional readings)

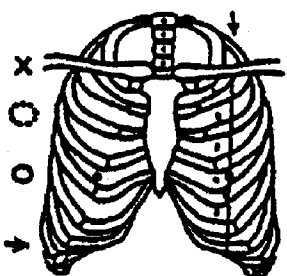
Systolic	Diastolic	5th Phase

E. Heart: Is there any:

Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No

(describe below-if more than one, describe separately)

	First Murmur	Second Murmur	
Location	<input type="checkbox"/>	<input type="checkbox"/>	Indicate:
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by
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:			Your comments and impression?
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"/>	



F. Do you find evidence of past or present abnormality of:

	Yes	No
1. eyes, ears, nose or throat? (If appreciable change, give measured eye impairment or hearing loss)	<input type="checkbox"/>	<input type="checkbox"/>
2. skin, breasts, lymph nodes, thyroid or other endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>
3. lungs, pleura or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>
4. abdomen or abdominal viscera?	<input type="checkbox"/>	<input type="checkbox"/>
5. kidneys, genitourinary tract?	<input type="checkbox"/>	<input type="checkbox"/>
6. brain or nervous system? (Include any tremor or abnormal reflexes)	<input type="checkbox"/>	<input type="checkbox"/>
7. musculoskeletal system? (Describe deformities or limitations)	<input type="checkbox"/>	<input type="checkbox"/>

G. Is a hernia present? (If "Yes," describe below) Yes No

H. Blood Vessels

1. Any evidence of arteriosclerosis?	<input type="checkbox"/>	<input type="checkbox"/>
2. Any varicosities?	<input type="checkbox"/>	<input type="checkbox"/>

Details or Remarks

Lab testing is required. Use proper kit and send to the Lab.

I certify that I have carefully examined _____ whose signature is affixed to the foregoing declarations and that examination was made in private at: my office residence of Proposed Insured place of business of Proposed Insured agency office other on this _____ day of _____ (month) _____ (year) at _____ a.m. p.m.

This examination is for: Disability Insurance Other purposes _____

Signed: _____
Medical Examiner

Examiner: Please give name of agent/broker or agency requesting this examination: _____
Address: _____

If not appointed examiner for Berkshire Life Insurance Company of America, please complete below:
State in which licensed: _____ Date of License: _____ License # _____
This Report Must Bear Date Examination Actually Made And Under No Circumstances Any Other.