MEDICAL DEPARTMENT

Please print names and addresses.
Supplement to Application to: **CATHOLIC FAMILY LIFE INSURANCE**

MEDICAL EXAMINATION REPORT - Part I
P.O. Box 11563, Milwaukee, Wis., 53211

PROPOSED INSURED: (Print Full Name) ____________________

DATE OF BIRTH: Month__________ Day__________ Year__________

1a. Name and address of your personal physician (IF NONE, SO STATE):

b. Date and reason last consulted:

c. Treatment given or medication prescribed:

2. Have you ever been treated for, or had any indication of:	Yes	No
a. Disorder of eyes, ears, nose or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c. Shortness of breath; persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disease of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐
j. Allergies; anemia or other disorder of the blood?	☐	☐
k. Deformity, lameness, or amputation?	☐	☐
3. Have you ever been treated for the use of alcohol or any habit-forming drugs? If so give complete details.	☐	☐
4. Have you smoked cigarettes in the past year or used any other nicotine products? If so, which?	☐	☐
5. To the best of your knowledge are you now pregnant? If "Yes" give date of expected delivery.	☐	☐
6. Has a member of the medical profession ever diagnosed you as having, or treated you for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immunological disorder?	☐	☐
7. Are you now under observation, treatment, or taking medication?	☐	☐
8. During the past seven years, have you:		
a. Been examined or been treated by a physician, chiropractor or psychologist?	☐	☐
b. Had an x-ray or electrocardiogram?	☐	☐
c. Had observation or treatment at a clinic or hospital?	☐	☐
d. Had a surgical operation scheduled or completed?	☐	☐
e. Made claim for or received payment for sickness or injury?	☐	☐
9. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
10. Were you ever postponed, declined, rated, or offered a modified plan for Life, Accident, or Health Insurance?	☐	☐

DETAILS of "Yes" answers (IDENTIFY QUESTION NUMBER; CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.

11. Family Record: (Indicate family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide.)

	If Living State of Health (If poor, give reason)	Deceased Age at Death	Deceased Cause of Death
Father			
Mother			
Brothers/ Sisters			

I hereby agree that all statements and answers in this application are full, complete, and true to the best of my knowledge and belief, and shall become part of any policy or contract issued on the basis of this application. I further agree that the Society may rely upon any statements or answers made relating to my health or illness in determining whether to accept this application for insurance.

Dated at: ____________________ (City, State) this__________ day of ____________________ (Date)

Examiner's Signature____________________ Proposed Insured's Signature ____________________

CATHOLIC FAMILY LIFE INSURANCE

Medical Examination Report - Part 2

Name: D.O.B.

Identification: ☐ Driver's License ☐ Other

Details of "Yes" answers. (Identify item.)

1.

HEIGHT (in shoes)	WEIGHT (clothed)	CHEST (full inspiration)	CHEST (forced expiration)	ABDOMEN, at umbilicus relaxed
ft. in.	lbs.	in.	in.	in.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _____lbs. ☐ Gain ☐ Loss - Cause?__________

Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

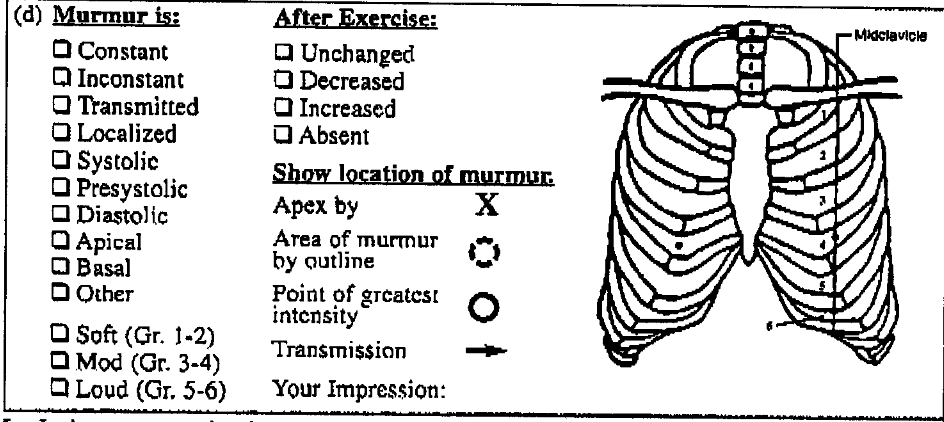
2. Blood Pressure (Record all readings)

	AT REST	AFTER EXERCISE	3 MINUTES LATER
Systolic			
Diastolic			

3. Pulse:

	AT REST	AFTER EXERCISE	3 MINUTES LATER
Rate			
Irregularities Per Min.			

4. Heart: (a) Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral, vascular, or other cardiovascular disorder? ☐ Yes ☐ No
(b) Is heart enlarged? ☐ Yes ☐ No (If yes, describe)
(c) Is murmur present? ☐ Yes ☐ No (If yes, complete 4d)



5. Is there on examination any abnormality of the following: (Check applicable and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing is markedly impaired, indicate degree correction.)	☐	☐
b. Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins)?	☐	☐
c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (including scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (incl. spine, joints, amputations, deformities)?	☐	☐
6. Evidence of cigarette smoking or other nicotine use?	☐	☐
7. Do you have pertinent information not brought out above?	☐	☐

8. Urinalysis:

SPECIFIC GRAVITY	ALBUMIN	SUGAR

Send specimen to laboratory as instructed.

I certify that I made this examination at __________ a.m. __________ p.m. on __________________ (Date)

Examination made at ☐ My office ☐ Individual's office ☐ Individual's home

Examiner's Name/Company____________________ Examiner's Signature ____________________

Are you in any way related to the proposed insured or to the agent? ☐ Yes ☐ No

Name of agent requesting examination:____________________ Tax I.D. Number ____________________

Address____________________ City/State/ZIP ____________________

Catholic Family Life Insurance

CALIFORNIA NOTICE OF AIDS VIRUS ANTIBODY TESTING AND AUTHORIZATION FOR TESTING AND DISCLOSURE

To determine your insurability, the insurer has requested a sample of your blood for testing analysis. One of the tests to be performed will be to determine the presence or absence of antibodies to the HIV virus. Antibodies to the HIV virus are produced by the body when it has been infected by the HIV virus. Antibodies are the body's way of fighting the infection. This is not a test for AIDS. It is a test for antibodies to the HIV virus which causes AIDS, and shows whether you have been exposed to the virus. The HIV antibody test is actually a series of tests. These tests are extremely reliable. Your blood sample is first subjected to an ELISA (enzyme-linked immunosorbent assay) test. If the test is positive, a second ELISA test is performed. If the second test is positive, a Western Blot Test is performed. Your test result is considered positive only after positive results are obtained on all three tests.

A negative test result indicates that the antibody has not been found in your blood. If you test negative there are three possible explanations:

- You have not been infected with the virus; or
- You have had contact with the virus but have not become infected; or
- You have been infected by the virus but have not yet produced antibodies.

Research indicates that most people produce antibodies within 2 - 8 weeks after infection. A very small number of people will never produce antibodies.

A negative result does not mean:

- That you are immune to the virus;
- That you have not been infected with the virus. You may have been infected and not yet produced antibodies.

A positive test result indicates that you have probably been infected with the AIDS virus and your body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. You may therefore assume you are contagious and capable of passing the virus to others. A positive test does not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. A positive test does not mean that you are immune to AIDS.

Normal test results will not affect your eligibility for insurance. A positive HIV antibody test 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 charges may be necessary.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. Negative 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. 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.

Public health authorities say that persons who are HIV antibody positive should be considered infected and capable of infecting others. Health authorities urge that everyone become educated about how to protect themselves from HIV infection. The virus is spread by sexual contact, needle sharing, or rarely through transfused blood or its components. The risk of infection with the virus is increased in drug users who share needles and in individuals with multiple sexual partners, either homosexual or heterosexual.

Most individuals infected with the virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever, including "nightsweats"
- Weight loss for no apparent reason
- Swollen lymph glands in the neck, underarm, or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth

These symptoms are also symptoms of many other illnesses. They may be symptoms of the virus only if they are unexplained by other illnesses. People who are infected remain infected indefinitely and can pass the virus to others. Only a doctor and a blood test can tell if someone is infected with HIV, the virus that causes AIDS.

NOTIFICATION OF TEST RESULTS

If your HIV 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, we ask that you give us the complete name and address of your physician. If your HIV test results are positive and you have chosen not to authorize a physician to receive the test results, we encourage you to contact a physician, the county department of health, the State Department of Health Services, local medical societies or alternative test sites for appropriate counseling. If your HIV test results are normal, no routine notification will be sent to you. If you wish to receive notice of the negative test results, please check here. ☐

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INFORMED CONSENT

I have read and understand this information statement. I voluntarily consent to have a blood sample taken. I consent to testing of that blood. I authorize the disclosure of the test results as described above.

Name of Proposed Insured (Please Print)

Signature of Proposed Insured

Date of Birth

Date

Address

City, State, and Zip Code

LISTING OF CALIFORNIA AIDS COUNSELING RESOURCES

San Francisco AIDS Foundation
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102
(415) 864-5855

Sacramento AIDS Foundation
1900 K Street, Suite 201
Sacramento, CA 95814
(916) 448-2437

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS Project Los Angeles
3670 Wilshire Blvd.,Suite 300
Los Angeles, CA 90010
(213) 380-2000

AIDS Services Foundation of
Orange County
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS Project - East Bay
400 40th Street, Suite 20
Oakland, CA 94609
(415) 420-8181

ARIS Project
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3272