

- Chase Insurance Life and Annuity Company
- Chase Insurance Life Company

File number

2500 Westfield Drive • Elgin, Illinois 60123-7836 - the "Company"
 Telephone 847-930-7000

Medical Examiner's Confidential Report

INSTRUCTIONS TO EXAMINER - This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to Proposed Insured. It should be sent to the home office upon completion.

Examination must be made in private. Proposed Insured must be properly prepared for careful physical examination. Please weigh and measure the Proposed Insured. Explain all positive findings under "Remarks." If for any reason you don't care to give certain special confidential information on this form, please enter such information on a separate sheet and mail directly to the Medical Director of the Company.

1. Proposed Insured _____
2. Height _____ft. _____in. Did you measure? Yes No Weight _____lbs. Did you weigh? Yes No
3. MEASUREMENTS (for males only)
 Chest: Full inspiration _____in. Forced expiration _____in. Abdomen: (at umbilicus) _____in.
4. Have you drawn a blood specimen and mailed it along with a urine specimen? Yes No
 Lab name _____
5. BLOOD PRESSURE: Initial reading _____ Additional readings _____
Report all readings. If initial reading is 140/90 or higher, or if the Proposed Insured has had hypertension or marked obesity, provide two additional blood pressure readings taken at intervals.
6. PULSE: Pulse at rest _____ Describe any irregularities _____

If examination is done by a physician, answer questions 7 and 8. Otherwise, go directly to question 9.

7. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

a. Brain or nervous system? (Test reflexes and coordination.)	a. <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Eyes, ears, nose, or throat?	b. <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Thyroid or lymph glands?	c. <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Heart or blood vessels?	d. <input type="checkbox"/> Yes <input type="checkbox"/> No

(If there is a history of rheumatic fever, or if you find any abnormality of heart size, rhythm or sounds, please complete question 8.)

e. Lungs?	e. <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Skin or extremities?	f. <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Genito-urinary system?	g. <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Stomach or abdominal organs?	h. <input type="checkbox"/> Yes <input type="checkbox"/> No
i. Is the liver enlarged?	i. <input type="checkbox"/> Yes <input type="checkbox"/> No

Remarks

Name of Proposed Insured _____

Medical Examiner's Confidential Report (Continued)

8. To be completed if question 7d is answered Yes, or if requested: (Explain all Yes answers under "Remarks.")
- | | |
|--|---|
| a. Is there a history of rheumatic fever or other infectious heart disease? | a. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Is there a history of congenital heart disease or other valvular abnormality? | b. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)? | c. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Is the first heart sound (S-1) normal? | d. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Is the second heart sound (S-2) normal? | e. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Are there gallops (S-3 or S-4)? | f. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Is/are there ejection sound(s) or systolic click(s)? | g. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Is/are there murmur(s) present? | h. <input type="checkbox"/> Yes <input type="checkbox"/> No |
- (If Yes, please describe under "Remarks," including timing (systolic or diastolic), intensity (grades 1 through 6), location and transmission or radiation. Construct a chest diagram in "Remarks" if you wish).

9. a. Does the Proposed Insured appear in any way unhealthy, disabled, or older than the stated age? Yes No
b. Do you know of any facts bearing upon the risk which are not brought out by the foregoing questions? Yes No
c. Was anyone else besides the Proposed Insured present at time of exam? (If Yes, who? _____) Yes No

10. a. Are you acquainted with the Proposed Insured? Yes No
If Yes, how well do you know the Proposed Insured?
 Known well Not known well
 Relative (state relationship) _____ How long known? _____
b. Are you the Proposed Insured's personal physician? Yes No

11. Exam was done at:
 Proposed Insured's office Examiner's office Proposed Insured's home Other _____

12. How did you identify the Proposed Insured? Driver's license number: _____
 Federal or state issued photo i.d. number: _____ Other: type _____ Number _____

Remarks

I hereby certify that I have personally examined _____ in private and have correctly and fully reported my findings.

Examined at _____, dated _____, at _____ AM PM

Signature of Examiner _____ Paramed MD

Examiner

Print Examiner's name _____ Paramed company _____

Examiner's phone number _____ Address _____

Address _____ City, State, Zip _____

City, State, Zip _____

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Application Part C: Medical Questionnaire

Questions apply to the Proposed Insured named in this Part C. Use the Details Section below and on Page 2 as needed to explain "Yes" answers.

1. Proposed Insured: Full Name (Last, First, MI)	Birthdate	Social Security number
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Purpose of this examination: New insurance Change of existing policy Reinstatement of lapsed policy

2. Have you ever had or been treated for:
- a. High blood pressure, chest pain, rheumatic fever, a heart condition, heart murmur, irregular heart rhythm, heart attack, or other disorder of the heart or blood vessels? Yes No
 - b. Diabetes, a thyroid disorder, or other disorder of the glands? Yes No
 - c. Cancer, tumor, lymph gland disorder, cyst, or any blood disorder? Yes No
 - d. Albumin, blood or sugar in the urine, kidney trouble, or any other disorder of the urinary or genital tract (including prostate)? Yes No
 - e. Epilepsy, convulsion, fainting spell, stroke, paralysis, or any other disorder of the brain or nervous system? Yes No
 - f. Asthma, chronic bronchitis, emphysema, pneumonia, sarcoidosis, tuberculosis, shortness of breath, or other lung or respiratory system disorder? Yes No
 - g. Ulcer, colitis, hepatitis, pancreatitis or other disorder of the esophagus, stomach, intestines, liver, gallbladder or pancreas? Yes No
 - h. Severe injuries or any disorder or deformity of the muscles, connective tissue, bones, joints, or skin? Yes No
 - i. Any impairment of sight or hearing or disorder of the eyes, ears, nose or throat? Yes No

3. Family record: (Use #7 for additional brothers or sisters.)

	Sex	Age	- Living - State of health	Age	- Deceased - Cause of death
Father					
Mother					
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F				
(list individually)	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				

4. Has any family member listed in #3 had cancer, diabetes, high blood pressure, heart disease, cardiovascular disease, or kidney disease? (If Yes: name family member, disorder(s) and age of onset of each.) Yes No

5. Have you ever used any form of tobacco? (If Yes, complete below.) Yes No
 Type: _____ Quantity: _____ Last used: _____ Number of years used: _____

6. Have you ever:
- a. used cocaine or any other illegal drugs? Yes No
 - b. sought treatment or counseling, or been advised to quit, reduce, seek treatment or counseling for the use of alcohol or drugs? Yes No
 - c. attended or been advised to attend a drug or alcohol self-help group? Yes No
 - d. been convicted of drug possession or distribution? Yes No
 - e. attempted suicide? Yes No

7. Details. Give complete details of all Yes answers.

Question Number	Date of occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practitioners, hospitals, and medical facilities consulted

Name of Proposed Insured _____

Application Part C: Medical Questionnaire (Continued)

Questions apply to the Proposed Insured named in this Part C. Use the Details Section below as needed to explain "Yes" answers.

8. In the past five years, have you: (If Yes to a or b: give complete details of each occurrence.)

a. consulted a doctor, medical or mental health professional? Yes No

b. had or been advised to have any blood tests, electrocardiograms, or other tests or studies other than a Human Immunodeficiency Virus (HIV) test or an Acquired Immune Deficiency Syndrome (AIDS) test? Yes No

9. Have you ever tested positive for the HIV antibody? Yes No

10. In the past two years, have you been advised to have any surgery or hospitalization which has not been completed? Yes No

11. In the past ten years, have you been under observation or received treatment in any hospital or other institution or medical facility? Yes No

12. a. What is your height? _____ weight? _____
 b. Have you lost any weight in the past year? If Yes, How much? _____ Reason? _____ Yes No

13. Are you currently:

a. receiving any illness or disability pension benefits or compensation? Yes No

b. taking, or have you been prescribed any medication? (If Yes, provide reason and name the medication and prescribing physician.) Yes No

14. Do you have any mental or physical disease or disorder, or are you under medical or psychiatric observation or treatment not already stated above? Yes No

15. Who is your personal physician? (If none, state none.)

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Date Last Seen _____ Why? _____

What tests were made? _____

Were the results normal? (If No, give details in #16.) Yes No

16. Details. Give complete details of all Yes answers.

Question Number	Date of occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practitioners, hospitals, and medical facilities consulted

All statements and answers to the questions listed above are true, complete, and correctly recorded, to the best of my knowledge and belief. I agree: that they shall form a part of the application to the Company indicated in Part A; that they shall be subject to the terms of the agreement found in Part B; and that they shall become a part of any policy based on this application. I will write to the Company if I choose to be interviewed if any investigative report is prepared.

I (we) hereby authorize upon request: any physician or medical practitioner; any hospital, clinic or other medically related facility; any insurance company; the Medical Information Bureau; and any other organization, institution or person, that has any records or knowledge relating to the Proposed Insured's health, habits, employment, income and finances should the Company make a request, to give any such records or knowledge to: the Company; its reinsurers, affiliates and producers; the Medical Information Bureau; and third parties who perform services for the Company in order to underwrite and administer any policy issued and offer financial products and services. This authorization is valid for 24 months from the date this form is signed. An exact copy of this authorization is valid as the original. A copy of this authorization will be given to me (us) or my (our) authorized representative on request.

Signed at (city and state) _____ Signature of Proposed Insured _____

on (Month/day/year) _____ Signature of Witness _____

Agent Examiner Other

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 is compiled from publicly available information, which is subject to change without notice to the Company. Therefore, the Company makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Company 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. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS Project - East Bay
(510) 634-8181

Central Valley AIDS Team
(208) 264-2436

AIDS Project Los Angeles
(213) 993-1600

Sacramento AIDS Foundation
(916) 448-2437

AIDS Service Foundation of Orange County
(714) 253-1500

San Diego AIDS Project
(618) 886-5000

ARIS Project
(408) 293-2747

San Francisco AIDS Foundation
(415) 487-3000