

- Mid-West National Life Insurance Company of Tennessee
- The MEGA Life and Health Insurance Company
- The Chesapeake Life Insurance Company

Office Use Only _____

Part A: Medical Questionnaire		
1. Proposed Insured		
First Name	Middle Initial	Last Name
Amount of Insurance	Birthdate	Social Security Number
Purpose of this examination: <input type="checkbox"/> New insurance <input type="checkbox"/> Change of existing policy <input type="checkbox"/> Reinstatement of lapsed policy		

3. Family Record	- Living -		- Deceased -	
	Age	State of Health	Age	Cause of Death
Father				
Mother				
Brothers (List individually)				
Sisters (List individually)				
(Use #7 for additional brothers or sisters.)				

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, stroke, or other disease of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes, a thyroid disorder, or other disease of the glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cancer, tumor, lymph gland disorder, cyst, or any blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Albumin, blood or sugar in the urine, kidney trouble, or any other disease of the urinary or genital tract (including prostate)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Epilepsy, convulsion, fainting spell, stroke, paralysis, or any other disease of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Asthma, chronic bronchitis, emphysema, pneumonia, sarcoidosis, tuberculosis, shortness of breath, or other lung or respiratory system ailment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Ulcer, colitis, hepatitis, pancreatitis or other disorder of the esophagus, stomach, intestines, liver, gallbladder or pancreas?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Severe injuries or any disease or deformity of the muscles, connective tissue, bones, joints or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Any impairment of sight or hearing or disease of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Has any family member listed in #3 had cancer, diabetes, high blood pressure, heart disease, or kidney disease? (If Yes, identify family member, disorder and age at onset.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Answer both parts a and b. a. Have you smoked cigarettes in the past 36 months? b. Have you used tobacco in any other form in the past 36 months? Type _____ Qty _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever: a. Used narcotics, hallucinogens, barbiturates, heroin, cocaine, amphetamines, or any other habit-forming drugs except as prescribed by a physician? b. Been advised by a physician, psychiatrist, or psychologist to quit or reduce your alcohol use? c. Been advised to seek, or received treatment or counseling for alcohol or other drug use? d. Been advised to attend or been a member of any self-help group? e. Been convicted of drug possession or distribution?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

7. Details of Items 2 through 6. Give complete details of all Yes answers. (Use #13, if needed, for further details.)				
Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Names and addresses of doctors, hospitals, and medical facilities consulted

PART A (Continued)

8. Have you:		9. What is your Height? _____ Weight? _____ Have you lost any weight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, amount? _____ Reason? _____		
a. Consulted a physician, psychiatrist, psychologist, or other medical practitioner in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Are you currently taking or have you been advised to take any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, list name of medication, reason & doctor's name and address).		
b. Had any blood studies (other than an HIV or AIDS test), electrocardiograms, stress electrocardiograms, or other medical tests or studies in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. To the best of your knowledge, do you have: a. Any mental illness or psychiatric disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Any physical disorder or disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Have you ever been diagnosed by a medical professional as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for the HIV (Human Immunodeficiency Virus) Virus? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. Who is your personal physician? (If none, state none) Name _____		
d. Been under observation or received treatment in any hospital or other institution or medical facility in the last ten years? <input type="checkbox"/> Yes <input type="checkbox"/> No		Street _____		
e. Been advised, in the last two years, to have any diagnostic test, surgery, or hospitalization which has not been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		City _____ State _____ Zip Code _____		
f. Ever received any sickness or disability pension benefits, or compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date last seen? _____ Phone () _____		
g. Ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No		Why? _____		
* _____		What tests were made? _____		
_____		Were the results normal? (If No, give details below.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Details of Items 8 through 12. Give complete details of all Yes answers. (Use #7, if needed, for further details).				
Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Names and addresses of doctors, hospitals, and medical facilities consulted

All statements and answers to the foregoing questions are, to the best of my knowledge and belief: (a) complete; and (b) true. I agree (a) that they shall form a part of my application; (b) that they shall be subject to the terms of the agreement found in the application; and (c) that they shall become a part of any policy based on my application.

Any person who knowingly and with intent to defraud an insurance company submits an application for insurance or statement of claim containing any materially false information or conceals information concerning any fact material thereto for the purpose of misleading could be considered committing a crime which is subject to criminal and civil penalties.

I hereby authorize any licensed physician or medical practitioner, any hospital, clinic, or other medical or medically related facility; any insurance company, the Medical Information Bureau; and any other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company, or their reinsurer, or the Medical Information Bureau any such information. This authorization is valid for two and one-half years from the date this form is signed. An exact copy of this authorization is as valid as the original.

Dated at _____
On _____
Month/Day/Year

Signature of Proposed Insured

Signature of Witness Agent Examiner

- Mid-West National Life Insurance Company of Tennessee
- The MEGA Life and Health Insurance Company
- The Chesapeake Life Insurance Company

Office Use Only _____

PART B: 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 the 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 applicant. 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.

The questions, which appear below, are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though such information may not be specifically requested on this form.

1. Proposed Insured		REMARKS:
2. Height _____ft. _____in. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight _____lbs. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> 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? Lab Name _____ <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Blood Pressure: Initial reading _____ Additional readings _____ <i>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.</i>		
6. Pulse Pulse at rest _____ Describe any irregularities _____		
If a physician does examination, 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) <input type="checkbox"/> Yes <input type="checkbox"/> No b. Eyes, ears, nose, or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Thyroid or lymph glands? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Heart or blood vessels? (if there is a history of rheumatic fever, or if you find any abnormality of heart size, rhythm or sounds, please complete question 8) <input type="checkbox"/> Yes <input type="checkbox"/> No		
e. Lungs? f. Skin or extremities? g. Genitourinary system? h. Stomach or abdominal organs? i. Is the liver enlarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART B: Medical Examiner's Confidential Report (continued)

<p>8. To be completed if question 7d is answered Yes or if requested: (Explain all Yes answers under "Remarks").</p>		<p>REMARKS</p>
<p>a. Is there a history of rheumatic fever or other infectious heart disease?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>b. Is there a history of congenital heart disease or other valvular abnormality?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>c. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>d. Is the first heart sound (S-1) normal?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>e. Is the second heart sound (S-2) normal?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>f. Are there gallops (S-3 or S-4)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>g. Is/are there ejection sound(s) or systolic click(s)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>h. Is/are there murmur(s) present? <i>(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)</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>i. Your opinion of the murmur(s): <input type="checkbox"/> Innocent or functional <input type="checkbox"/> Mitral regurgitation <input type="checkbox"/> Mitral stenosis <input type="checkbox"/> Aortic insufficiency <input type="checkbox"/> Other (specify under "Remarks")</p>		
<p>9. a. Does the Proposed Insured appear in any way unhealthy, or older than the stated age?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>b. Do you know of any facts bearing upon the risks, which are not brought out by the foregoing questions? *</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>c. Was anyone else besides the Proposed Insured present at time of exam? (If Yes, who?)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>10. a. Are you acquainted with the Proposed Insured? If Yes, how well do you know the Proposed Insured? <input type="checkbox"/> Known well <input type="checkbox"/> Not known well <input type="checkbox"/> Relative (state relationship) _____ How long known? _____ b. Are you the Proposed Insured's personal physician?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>11. Exam was done at: <input type="checkbox"/> Proposed Insured's office <input type="checkbox"/> Examiner's office <input type="checkbox"/> Proposed Insured's home <input type="checkbox"/> Other</p>		
<p>12. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other photo i.d.</p>		
<p>I hereby certify that I have personally examined _____ _____ In private and have correctly and fully reported my findings. Examined at _____ this _____ day of _____, 20____, at _____ am/pm X _____ Signature of Examiner <input type="checkbox"/> Paramed <input type="checkbox"/> MD</p>		<p>Examiner Print Examiner's Name _____ Examiner's phone number (____) _____ Address _____ Paramed Company _____ Address _____</p>

The Chesapeake Life Insurance Company
Home Office: 1331 W Memorial Road, Suite 112, Oklahoma City, OK 73114 1-800-725-7887

NOTICE AND CONSENT FOR TESTING
WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid (saliva) and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test, which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturers specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay, which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay, which is reactive according to the standards of performance and results specified in the manufacturers Federal Food, and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test abnormalities 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 RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurer, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood, oral fluid (saliva) or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you:

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the blood, oral fluid (saliva) and or urine sample from me, the testing of that sample, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or facsimile of this form will be as valid as the original.

Proposed Insured

Date of Birth

Name and Address of Designated Physician: *

Signature of Proposed Insured or Parent/Guardian

Date

State of Resident