

THE CINCINNATI LIFE INSURANCE COMPANY

MEDICAL EXAMINER'S REPORT

10. a.	Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.
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b. Did you weigh? Yes No Did you measure? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	{ 4th phase		
	{ 5th phase		

12. Pulse:

Rate	At Rest	After Exercise	3 Minutes Later
Irregularities per min.			

13. Heart: Is there any:

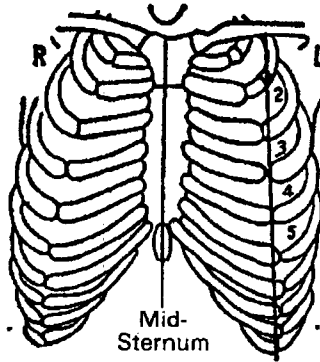
Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Location

Indicate:

Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by X
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by
Localized	<input type="checkbox"/>	<input type="checkbox"/>	
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by
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:

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"/>

For comments and your impression

14. Is there, on examination, any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>
15. a. Are there any hernias?	<input type="checkbox"/>	<input type="checkbox"/>
b. any hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you aware of additional medical history?	<input type="checkbox"/>	<input type="checkbox"/>

(A confidential report may be sent to the Medical Director)

	Yes	No
17. a. Are you related to Applicant?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you associated with the Applicant in any business or financial venture?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you any reason to believe that he uses or has used alcoholic beverages or drugs to excess?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers (identify item).

19. A specimen is to be forwarded to the Home Office:

Are you forwarding a specimen of proposed Insured's urine? _____

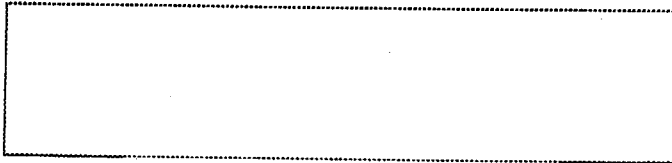
Specific Gravity	Albumin	Sugar

To the Examining Physician:
 The Company's normal examination fee is \$30.00. If you feel that a reasonably higher charge is warranted, please indicate amount as follows:
 Amount of Fee \$ _____

Your overall estimate of this applicant: First Class Good Fair Poor

Examined at applicant's residence [] on _____ at _____ a.m. _____ p.m.
 applicant's business [] (Mo.) (Day) (Year)
 examiner's office []

Signature of Examiner _____
 Please print or type name _____
 Examiner's Social Security Number or Taxpayer Identifying Number _____
 Examiner's address _____ (Please Print)
 At request of _____, Agent Office address _____



INSURANCE COMPANY

NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

THE HIV ANTIBODY TEST

To evaluate your insurability, the Insurer named above has requested that you provide a specimen sample of your blood, urine or saliva 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. A series of tests will be performed by a licensed laboratory through medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, it is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when infection occurred within the previous 3-6 months prior to the test.

MEANING OF TEST RESULTS

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.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

COUNSELING

Many public health organizations have recommended that before taking an AIDS-related test, a person should 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. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have any questions or concerns, you may wish to consult your own physician or health care provider. A list of counseling resources is provided for your information.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.

Name of Physician: _____ Address _____

CONFIDENTIALITY OF TEST RESULTS

All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. No other disclosure will be made of the results except as required by law.

CONSENT

I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and 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 of this form will be as valid as the original.

Name of Proposed Insured (Please Print)

Date

Signature of Proposed Insured

Date