

Answers to questions must be made to the Medical Examiner who should see that each answer is full and satisfactory. Neither the agent nor any third person, except office nurse, should be present.

Social Security Number _____

Proposed Insured _____ Birth Date (MM/DD/YYYY) _____
 First Name Middle Initial Last Name Month Day Year

1. a. Name and address of your personal physician? _____
 (If none, so state)
- b. Date and reason last consulted? (MM/DD/YYYY) _____
- c. What treatment was given or medication prescribed? _____

- | | | |
|--|--------------------------|--------------------------|
| 2. To the best of your knowledge and belief, have you ever been treated for or ever had any known indication of: | Yes | No |
| a. Disorder of eyes, ears, nose, or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes; thyroid or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor, or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now under observation or taking treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any change in weight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever used marijuana, amphetamines, LSD, barbiturates, heroin, or other addictive or non-addictive drugs, except as prescribed by a physician? (If yes, specify type and frequency of use.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken any treatment for alcohol or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other than above, have you within the past 5 years: | | |
| a. Had any mental or physical disorder not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury, surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had electrocardiogram, X-ray, other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you used any form of tobacco or any nicotine products within the past 12 months? If yes, form used. | <input type="checkbox"/> | <input type="checkbox"/> |

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.

	Age if living?	Cause of Death?	Age at Death?
Father _____			
Mother _____			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

- | | | |
|--|--------------------------|--------------------------|
| 12. Females only: | Yes | No |
| a. Have you ever had any disorder of menstruation, pregnancy, female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had repeated miscarriages, difficult labors, stillbirth or cesarean operation or any complication of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. To the best of your knowledge and belief are you now pregnant? If yes, give date (MM/DD/YYYY) of expected delivery | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby declare that the above answers and statements are correct and fully recorded by the medical examiner and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my health or give Colonial Life & Accident Insurance Company, or its reinsurer(s), any such information. A photographic copy of this authorization shall be as valid as the original.

Dated at _____ on (MM/DD/YYYY) _____

in Presence of _____

Medical Examiner

Signature of Proposed Insured

MEDICAL EXAMINER'S REPORT TO COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, Columbia, S. C.

The Company requires the Medical Examiner to fill out the answers and to see that each answer is full and satisfactory. The examination should be made in private; if a third person, other than office nurse, is present, explain why.

13. How long and how well have you known Proposed Insured?

14a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only:		
		Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

b. Did you weigh? Yes No Did you measure? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

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

15. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	5th phase		

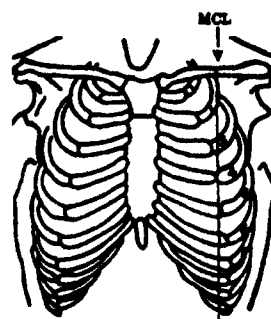
16. Pulse: At Rest After Exercise 3 Minutes Later

Rate _____
 Irregularities per min. _____

17. Heart: Is there any:

Enlargement Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No
 (describe below — if more than one, describe separately)

Location

Constant <input type="checkbox"/>	<input type="checkbox"/>	Indicate:	
Inconstant <input type="checkbox"/>	<input type="checkbox"/>		
Transmitted <input type="checkbox"/>	<input type="checkbox"/>		
Localized <input type="checkbox"/>	<input type="checkbox"/>		
Systolic <input type="checkbox"/>	<input type="checkbox"/>	Apex by	<input type="checkbox"/>
Presystolic <input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	<input type="checkbox"/>
Diastolic <input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	<input type="checkbox"/>
Soft (Gr. 1-2) <input type="checkbox"/>	<input type="checkbox"/>	Transmission by	<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: **For comments and your impression?**

Increased
 Absent
 Unchanged
 Decreased

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

(a) Eyes, ears, nose, mouth, pharynx?	Yes	No
(If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin (incl. sars); 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"/>

19. (a) Are there any hernias? Yes No (b) Any hemorrhoids?

20. Are you aware of additional medical history?

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

Urinalysis: Specific Gravity	Albumin	Sugar
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Mail Specimen: if over age 60; or if there is history or finding of albumin or sugar; or of any genito-urinary or cardiovascular disease or disorder; or if the amount of insurance applied for (including any term rider) is \$30,000 or more; or if application is for health insurance.

Is specimen being sent to Home Office? Yes No

I certify that I made this examination at A.M. P.M. on the _____ day of _____, _____
 Examination made at my office. Proposed Insured's home.
 Proposed Insured's office. Other: _____

Name of agent who authorized this examination _____

THIS REPORT NOT TO BE GIVEN TO ANY COMPANY REPRESENTATIVE. MAIL DIRECTLY TO HOME OFFICE.

Signature of Examiner _____
 I graduated from _____
 Medical School in the year _____
 M.D., Address _____
 Street or Box No. _____
 City _____ State _____ Zip Code _____

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the Insurer named below (the Insurer) has requested that you provide a sample of your blood 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 and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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 are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or 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 needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover 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.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, 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 result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you do not wish to know the results of the test, initial here: _____ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____ The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

_____ The result will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed: _____

MM/DD/YYYY

Colonial Life & Accident Insurance Company
P. O. Box 1365. Columbia, SC 29202