

# Medical Questionnaire

Conseco Insurance Company  
**A life and health insurance company**  
 Administrative Office: 11815 North Pennsylvania Street  
 Carmel, IN 46032

To be completed by the Medical Examiner, signed in his or her presence and witnessed by him or her.

**PLEASE PRINT ALL ANSWERS**

Proposed Insured: <div style="display: flex; justify-content: space-between; font-size: small;"> <span>First      M.I.      Last</span> <span>Birthdate: Month/ Day/ Year</span> </div>																									
1. a. Name and Address of your personal physician or medical provider(if none, state none) ..... b. Date and Reason last visited ..... c. What treatment was given or medication prescribed? .....																									
2. Have you within the past 10 years been treated for or had any known indication of: <table style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 80%;"></td> <td style="text-align: right; font-weight: bold; font-size: small;">Yes No</td> </tr> <tr> <td>a. Disorder of eyes, ears, nose, or throat? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; depression, mental or nervous disorder? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, congestive heart failure or other disorder of the heart or blood vessels? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver, or gallbladder? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, breasts or reproductive organs? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>g. Diabetes; thyroid or other endocrine disorders? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>h. Neuritis, sciatica, arthritis, or disorder of the muscles or bones, including the spine, back, or joints? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>i. Deformity, lameness, or amputation? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>j. Disorder of skin, lymph glands, cyst, tumor, or cancer? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>k. Allergies; anemia or other disorder of the blood (excluding HIV)? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>			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; depression, 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, congestive heart failure or other disorder of the heart or blood vessels? .....	<input type="checkbox"/> <input type="checkbox"/>	e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, diverticulitis, 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, breasts 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, arthritis, 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 (excluding HIV)? .....	<input type="checkbox"/> <input type="checkbox"/>
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<b>DETAILS of "Yes" answers.</b> Identify Question Number, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.																									
3. Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession? ..... <input type="checkbox"/> <input type="checkbox"/>																									
4. Have you ever been advised by a physician to reduce your consumption of alcohol or drugs? .. <input type="checkbox"/> <input type="checkbox"/>																									
5. Have you ever sought advice or been treated for use of alcohol or drugs?..... <input type="checkbox"/> <input type="checkbox"/>																									
6. Within the past two years have you on the average consumed more than two alcoholic beverages each day or more than five alcoholic beverages on any occasion? ..... <input type="checkbox"/> <input type="checkbox"/>																									
7. Within the past 10 years have you used (other than prescribed by a licensed physician) opium, heroin, barbiturates, sedatives, tranquilizers, marijuana, cocaine, amphetamines, hallucinogens, psychedelic drugs, LSD, DMT, mescaline, narcotics, stimulants, morphine, or any other controlled substance not prescribed for your use by a physician? ..... <input type="checkbox"/> <input type="checkbox"/>																									
8. a. Have you used tobacco in the last 36 months? ..... <input type="checkbox"/> <input type="checkbox"/> If so what form(s) ..... b. Date last used: (Month/Year) .....																									
9. Are you now under observation or taking treatment? ..... <input type="checkbox"/> <input type="checkbox"/>																									
10. Other than the above, have you within the past 5 years: <table style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 80%;">a. Had a checkup, consultation, illness, injury, surgery? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>b. Been a patient in a hospital, clinic, sanitarium, nursing home, long term care facility, or other medical facility? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>c. Had electrocardiogram, X-ray, other diagnostic test (excluding HIV test) .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>d. Been advised to have any diagnostic test (excluding HIV test), hospitalization, treatment, or surgery which was not completed? .....</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>		a. Had a checkup, consultation, illness, injury, surgery? .....	<input type="checkbox"/> <input type="checkbox"/>	b. Been a patient in a hospital, clinic, sanitarium, nursing home, long term care facility, or other medical facility? .....	<input type="checkbox"/> <input type="checkbox"/>	c. Had electrocardiogram, X-ray, other diagnostic test (excluding HIV test) .....	<input type="checkbox"/> <input type="checkbox"/>	d. Been advised to have any diagnostic test (excluding HIV test), hospitalization, treatment, or surgery which was not completed? .....	<input type="checkbox"/> <input type="checkbox"/>																
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11. Are you planning to consult a doctor for any physical symptoms you have experienced within the past 60 days? ..... <input type="checkbox"/> <input type="checkbox"/>																									
12. Have you ever had military deferment, rejection or discharge because of a physical or mental condition? ..... <input type="checkbox"/> <input type="checkbox"/>																									
13. Have you ever requested a pension, benefits, or payment because of an injury, sickness or disability? ..... <input type="checkbox"/> <input type="checkbox"/>																									
14. Family History: Stroke, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ..... <input type="checkbox"/> <input type="checkbox"/>																									
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 20%;">Age if Living</th> <th style="width: 40%;">Cause of Death?</th> <th style="width: 20%;">Age at Death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers and Sisters</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="font-size: x-small;">No. Living _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="font-size: x-small;">No. Dead _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Age if Living	Cause of Death?	Age at Death	Father				Mother				Brothers and Sisters				No. Living _____				No. Dead _____			
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I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, the MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my family members proposed for insurance, or our health, to give the Company or its reinsurers, any such information it may require to determine eligibility for insurance. A photographic copy of the authorization shall be as valid as the original.

I represent that the above statements and answers are true and complete to the best of my knowledge and belief, and I agree that such statements and answers shall be part of the application and are made to induce the Company to issue the policy or contract applied for.

Dated at \_\_\_\_\_  
 City/State

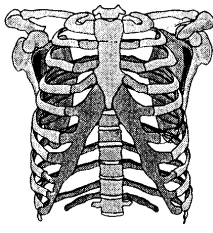
Signature of \_\_\_\_\_  
 Proposed Insured  
 Child's Parent if Proposed Insured is under age 16

On \_\_\_\_\_  
 Month/ Day/ Year

Signature of \_\_\_\_\_  
 Medical Examiner

**Medical  
Examiner's Report**

Conseco Insurance Company  
Administrative Office: 11815 North Pennsylvania Street  
Carmel, IN 46032

15. Name (Please Print)		DETAILS of "Yes" answers. (Identify Item)		
16. Height (In Shoes) ..... FT. IN. Weight (Clothed) ..... LBS. Abdomen, at Umbilicus relaxed ..... IN.		Chest (Full Inspiration) ..... IN. Chest (Forced Expiration) ..... IN.		
		<b>Yes No</b>		
a. Did you weigh? .....		<input type="checkbox"/> <input type="checkbox"/>		
b. Did you measure? .....		<input type="checkbox"/> <input type="checkbox"/>		
c. Weight change in past year? .....		<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ Lbs. – Cause? .....		<input type="checkbox"/> <input type="checkbox"/>		
d. Is appearance unhealthy or older than stated age? .....		<input type="checkbox"/> <input type="checkbox"/>		
17. <b>Blood Pressure</b> (Record all readings)				
Systolic				
4th phase				
Diastolic				
5th phase				
18. <b>Pulse</b>				
Rate		At Rest	After Exercise	3 Minutes Later
Irregularities Per Min.				
19. <b>Heart</b> <span style="float: right;"><b>Yes No</b></span>				
a. Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? .....				
<input type="checkbox"/> <input type="checkbox"/>				
b. Is heart enlarged? (if yes, describe) .....				
<input type="checkbox"/> <input type="checkbox"/>				
c. Is murmur present? (If yes, complete 14d) .....				
<input type="checkbox"/> <input type="checkbox"/>				
d. Murmur is:				
<input type="checkbox"/> Systolic		<input type="checkbox"/> Soft (Gr. 1-2)		
<input type="checkbox"/> Constant		<input type="checkbox"/> Presystolic		
<input type="checkbox"/> Inconstant		<input type="checkbox"/> Diastolic		
<input type="checkbox"/> Transmitted		<input type="checkbox"/> Loud (Gr. 5-6)		
<input type="checkbox"/> Localized		<input type="checkbox"/> Aortic		
<input type="checkbox"/> Other				
e. After Exercise Murmur is:		f. Show Location Of:		
<input type="checkbox"/> Unchanged		Apex by ..... X		
<input type="checkbox"/> Decreased		Area of murmur by ..... <input type="checkbox"/>		
<input type="checkbox"/> Increased		Point of greatest intensity.. <input type="checkbox"/>		
<input type="checkbox"/> Absent		Transmission ..... →		
				
g. Your Impression?				
20. Is there on examination any abnormality of the following: ..... <b>Yes No</b>				
(Circle applicable items and give details) .....				
<input type="checkbox"/> <input type="checkbox"/>				
a. Eyes, ears, nose, mouth, pharynx (If vision or hearing markedly impaired, indicate degree and correction) .....				
<input type="checkbox"/> <input type="checkbox"/>				
b. Skin (incl. Scars), lymph nodes, blood vessels (include varicose veins) .....				
<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 (including scars) .....				
<input type="checkbox"/> <input type="checkbox"/>				
f. Genitourinary system.....				
<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"/>				
21. a. Are there any hernias? .....				
<input type="checkbox"/> <input type="checkbox"/>				
b. Any hemorrhoids? .....				
<input type="checkbox"/> <input type="checkbox"/>				
22. Have you any pertinent information not brought out above? .....				
<input type="checkbox"/> <input type="checkbox"/>				
Female Applicants: Are you currently in menses? .....				
<input type="checkbox"/> <input type="checkbox"/>				
A Urine Specimen must be obtained with all exams and forwarded to :				
<input type="checkbox"/> CRL..... Barcode#:				

Examiner must mail this form when completed direct to the Insurance Company: P.O. Box 1972, Carmel, IN 46082-1972  
1-800-525-7662 / Fax 317-817-2343

I certify that I made the examination at **Time**  AM /  PM **Date** **Location**  my office  individual's office  
 individual's home  Other

**This examination should be made in private. If 3rd person present, give details**

Examiner's Signature: Examiner's Address:

Examiner's Phone: Name of Agent: