

COUNTRY LIFE INSURANCE COMPANY®
COUNTRY INVESTORS LIFE ASSURANCE COMPANY®

1711 GE Road, P.O. Box 2000
 Bloomington, IL 61702-2000
 Phone (309) 821-3000

PART TWO-
STATEMENT TO MEDICAL EXAMINER

PLEASE USE BLACK INK AS THIS FORM WILL BE PHOTOED.

PROPOSED INSURED		BIRTH DATE:		
First Name	Middle Name	Last Name	Mo.	Day
1. a. Name and address of your personal physician? (If none, so state) _____ _____ _____ Years attending you: _____ b. Date and reason last consulted? _____ c. What treatment was given or medication prescribed? _____ _____				
2. Have you in the past 10 years been treated for or had: a. Disorder of eyes, ears, nose, throat or mouth? <input type="checkbox"/> YES <input type="checkbox"/> NO b. Dizziness, fainting, convulsions, epilepsy, headache, speech defect, paralysis or stroke; mental or nervous disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO c. Bronchitis, pleurisy, asthma, emphysema, pneumonia, tuberculosis or chronic respiratory disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO d. Chest pain, irregular or rapid heart rate, high blood pressure, rheumatic fever, chorea, heart murmur, heart attack or other disorder of the heart or blood vessels? <input type="checkbox"/> YES <input type="checkbox"/> NO 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"/> YES <input type="checkbox"/> NO f. Sugar, albumin, blood or pus in urine, venereal disease; kidney stone or other disorder of the kidney or bladder? <input type="checkbox"/> YES <input type="checkbox"/> NO g. Disorder of the reproductive system consisting of urethra, testes, prostate, seminal vesicles, uterus, uterine tubes, ovaries or breasts? <input type="checkbox"/> YES <input type="checkbox"/> NO h. Diabetes, thyroid or other glandular disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO i. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? <input type="checkbox"/> YES <input type="checkbox"/> NO j. Deformity, lameness or amputation? <input type="checkbox"/> YES <input type="checkbox"/> NO k. Disorder of skin, cyst, tumor or cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO l. Allergies, anemia? <input type="checkbox"/> YES <input type="checkbox"/> NO m. Any mental or physical disorder and/or impairment of health not revealed above? <input type="checkbox"/> YES <input type="checkbox"/> NO	DETAILS of "Yes" answers, (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)			
3. In the past 10 years have you been treated or received a medical diagnosis by a physician for: a. Shortness of breath, persistent hoarseness or cough or blood spitting? <input type="checkbox"/> YES <input type="checkbox"/> NO b. Disorder of lymph glands, or other disorder of the blood? <input type="checkbox"/> YES <input type="checkbox"/> NO c. Acquired Immune Deficiency Syndrome(AIDS), AIDS Related Complex(ARC), or AIDS Related Condition or tested positive for antibodies to the AIDS(HIV) virus? <input type="checkbox"/> YES <input type="checkbox"/> NO				

4. a. In the past 6 months have you taken any prescribed medication or been advised to restrict your diet or living habits?	YES	NO	DETAILS of "Yes" answers, (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)
	<input type="checkbox"/>	<input type="checkbox"/>	
b. Have you gained or lost weight in the past year? (If "Yes", give pounds gained or lost and reason.)	<input type="checkbox"/>	<input type="checkbox"/>	
5. OTHER THAN PREVIOUSLY LISTED, have you within the past 5 years:			
a. Had a checkup, consultation, illness, injury, or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had electrocardiogram, x-ray, or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? (If "yes", explain)	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are you now contemplating any surgical procedure or hospitalization, or do you plan to seek other medical advice or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
7. AGE 15 AND OVER			
a. Any use of alcohol, or any habit forming drugs or been treated for alcohol or drug abuse? (Define amount consumed, inhaled, or smoked each day, week or month.)	<input type="checkbox"/>	<input type="checkbox"/>	
b. During the past 12 months used tobacco in any form? (Define type and amount used.)	<input type="checkbox"/>	<input type="checkbox"/>	
c. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
8. IF LESS THAN ONE YEAR OF AGE			
a. Was the child's birth abnormal or premature?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Give birthweight: _____ lbs./kilos _____ oz./grams			

9. a. To the best of your knowledge have any of your parents or brothers or sisters had diabetes, cancer, heart disease or mental illness, including Huntington's Chorea? (If yes, explain)				<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Family History	Age if Living	State of Health or Cause of Death		Age at Death	
Father					
Mother					
Brothers and Sisters					
No. Living					
No. Dead					

I certify that I am the person named as the Proposed Insured, and that the foregoing statements and answers which are made in the Part 2 - Statement to Medical Examiner, each of which I have made and read, and which with the application shall form the basis of the contract of insurance, are complete, true and correctly recorded.

Dated _____, _____.

WITNESSED BY EXAMINER

SIGNATURE OF PROPOSED INSURED IF AGE 15 OR OLDER,
OR PERSON GIVING HISTORY IF UNDER AGE 15

PART THREE - STATEMENT OF MEDICAL EXAMINER

10a. Height (in shoes) _____ ft. _____ in. or _____ ft. _____ in.	Weight (Clothed) _____ lbs. _____ kg.	b. Did you weigh? <input type="checkbox"/> YES <input type="checkbox"/> NO	c. Did you measure? <input type="checkbox"/> YES <input type="checkbox"/> NO	d. General physical appearance? <input type="checkbox"/> Healthy <input type="checkbox"/> Unhealthy
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If appearance is unhealthy please explain why? _____

11. Blood Pressure (record ALL readings, Age 10 and over-younger if medically indicated). Please include 3 readings 5 min. apart if resting systolic BP is greater than 140 or diastolic greater than 90.

Systolic			
Diastolic 5th Phase			

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

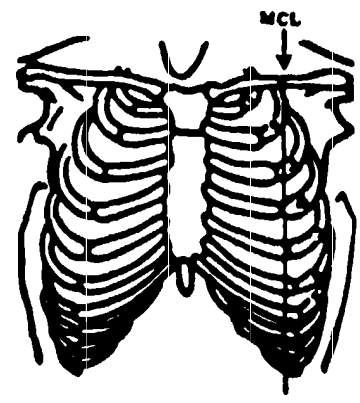
13. HEART: Is there any ? (describe below - if more than one, describe separately)

- a. Enlargement yes No
- b. Dyspnea yes No
- c. Murmur(s) yes No
- d. Edema yes No

LOCATION	1ST MURMUR	2ND MURMUR

- | | | |
|-----------------|--------------------------|--------------------------|
| Constant | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> |
| Diastolic | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> |

- INDICATE:**
-
- Apex by **X**
 - Murmur Area by
 - Points of greatest intensity by **O**
 - Transmission by **▶**



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

	YES	NO
a. Eyes, ears, nose, mouth or pharynx? (if vision or hearing markedly impaired, indicate degree and correction)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin; 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 including 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"/>

FEE

Please indicate the fee for this service that you feel is in accord with your usual and customary charges.

\$ _____

MEDICAL EXAMINER'S VOUCHER

- COUNTRY LIFE INSURANCE COMPANY
- COUNTRY INVESTORS LIFE ASSURANCE COMPANY

**PLEASE
Print, Type or
Rubber Stamp Your
Name & Address**

Name of Examiner

Name of Proposed Insured

Social Security or Tax No. _____

Address _____

Name of Agent

Date of Examination

THIS VOUCHER SERVES AS BASIS FOR PAYMENT OF THIS EXAMINATION.
DO NOT DETACH THIS VOUCHER