

MEDICAL QUESTIONNAIRE

Office Use Only: 02 or 16

Supplement to Application (Part II)

Policy/Order Number _____

Proposed Insured: _____

First Name Middle Initial Last Name

Date of Birth: (mo./day/yr.) _____ / _____ / _____ Height _____ ft. _____ in. Weight _____ lbs.

1. a. Name and address of personal physician (If none, write "none") _____

 b. Date and reason last consulted _____
 c. What treatment was given and/or medication prescribed? _____
 d. What tests/studies were completed? What were the results? _____
2. Have you ever been treated for or diagnosed by a member of the medical profession as having:
 - a. Allergies; disease(s) or disorder(s) of eyes, ears, nose or throat? Yes No
 - b. Dizziness, fainting, convulsion, epilepsy, headache; stroke or paralysis? Yes No
 - c. Depression, mental or nervous disorder(s), anxiety or attempted suicide? Yes No
 - d. Shortness of breath, persistent hoarseness or cough, bronchitis, pneumonia, tuberculosis, asthma, emphysema/chronic obstructive pulmonary disease (COPD), chronic respiratory disorder or sleep apnea? Yes No
 - e. Chest pain, palpitation(s), high blood pressure, rheumatic fever, heart murmur or valvular heart disease, heart attack or other disorder(s) of the heart or blood vessels? Yes No
 - f. Hepatitis (A,B,C or other), jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, disorder of the stomach, intestines, liver or gallbladder? Yes No
 - g. Sugar, blood, protein or other urinary abnormalities; stone(s) or other disorder of the kidney, bladder, prostate or reproductive organs? Yes No
 - h. Diabetes; thyroid or other endocrine disorder(s)? Yes No
 - i. Neuritis, sciatica, arthritis, gout, deformity, amputation, Multiple Sclerosis, Muscular Dystrophy or other disorder(s) of the muscles, bones, spine, back or joints? Yes No
 - j. Disorder(s) of skin; lupus or other connective tissue disease? Yes No
 - k. Cyst(s), polyp(s), tumor(s) or cancer? Yes No
 - l. Anemia or other disorder(s) of the blood (not including HIV) or lymph glands? Yes No
3. Have you had angioplasty, stent placement or bypass surgery? Yes No
4. Have you ever been diagnosed or treated by a member of the medical profession for an immune deficiency disorder (not including HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or sexually transmitted disease(s) (not including HIV) including gonorrhea, syphilis, genital herpes or venereal warts? Yes No
5. a. Are you now under observation or taking treatment? Yes No
 b. Have you had any change in weight in the past year? Yes No

Please provide details of "Yes" answers. (IDENTIFY QUESTION, CIRCLE APPLICABLE ITEMS: Include diagnoses, treatment, dates, duration and names and addresses of all attending physicians and medical facilities.)

ADDITIONAL QUESTIONS & SIGNATURE ON REVERSE SIDE

6. Other than as previously stated on this questionnaire, have you within the past five years:
- a. Had a mental or physical disorder? Yes No
 - b. Had a checkup, consultation, illness, injury or surgery? Yes No
 - c. Been evaluated in a hospital, emergency room or other medical facility? Yes No
 - d. Had an electrocardiogram, x-ray or other diagnostic test(s)? Yes No
 - e. Been advised to have any diagnostic test(s), hospitalization or surgery which was not completed? Yes No

Please provide details of "Yes" answers. _____

7. Have you:
- a. Ever requested or received short or long term disability payments because of injury or sickness? Yes No
 - b. Ever used sedatives, stimulants, narcotics or hallucinogens except as prescribed by a physician? .. Yes No
 - c. Ever been treated or advised to seek treatment for use of alcohol or drugs? Yes No

Please provide details of "Yes" answers. _____

8. Have you used any form of tobacco or nicotine substitute within the last 36 months? Yes No
 If so, what form? _____ Date last used? _____
 (Month/Year)

9. Any family history of diabetes, cancer, high blood pressure, heart or kidney disease, cerebrovascular disorder, mental illness or suicide? Yes No

Relationship	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/ Sisters			

Please provide details of "Yes" answers _____

Any person who knowingly presents a false statement or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

I have read my answers to the above questions, and they are true and complete to the best of my knowledge and belief.

 Signature of Proposed Insured
 (If Under Age 16, Parent or Guardian Must Sign)

 Date

 Witness By - Signature

For Paramedical Examiner or Physician use only:

1a. Measured Height _____ ft. _____ in. 1b. Measured Weight _____ lbs.

1c. Chest (full inspiration) _____ ins. Chest (forced expiration) _____ ins.
 Abdomen (at Umbilicus) _____ ins.

1d. Did you measure? Yes No 1e. Did you weigh? Yes No

2. Blood Pressure: If first reading is over 140 systolic or 90 diastolic, take at least two additional complete readings two or three minutes apart. Record all readings.

Systolic	_____	_____	_____
Diastolic (5th phase)	_____	_____	_____

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

4. Was a urinalysis and/or blood chemistry profile sent to the laboratory? Yes No



2000 Heritage Way • Waverly, Iowa 50677

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

Office Use Only: 91

To evaluate your insurability, CUNA Mutual Life Insurance Company has requested that you provide a sample of your blood, urine, or oral fluid for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood, urine, or oral fluid sample and that underwriting decisions may be based on the test results.

HIV Antibody Test

The HIV antibody test is a series of tests performed by a licensed laboratory through a medically accepted procedure which is designed to detect the presence of antibodies to the AIDS virus rather than detect the virus itself. Antibodies to the AIDS virus are found in the blood, urine and/or other body fluids of most patients with AIDS and AIDS-related complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus.

Your blood, urine and/or other body fluids sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your blood, urine and/or other body fluids specimen will then be subjected to another, more specific technique called the Western Blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western blot test.

Meaning of Test Results

Positive Test Results. If your antibody test is positive, it does not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. However, there is a risk that a person who has not been exposed to the virus will be incorrectly classified by the test as having a positive test. This is called a "false positive" result.

Negative Test Results. If your test is not positive, you most likely have not been infected by the virus. However, it is possible to have been infected with the virus within the past year and not have developed antibodies that cause a positive test result. It is possible to receive a "false negative" result.

Notification of Test Results

If your HIV antibody test results are negative, no routine notification will be sent to you unless requested. If your test results are positive, a trained person should deliver that information so that you can clearly understand what the results mean. We ask that you please list your personal physician below so that we may forward the results to them if necessary.

Name of Physician: _____

Address: _____

Confidentiality of Test Results

All test results will 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. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes which are not specific to the testing of HIV antibodies. The release for disclosures discussed in this paragraph will be effective for 2½ years from the date shown below.

CONSENT

I have read and I understand this Consent Form for HIV Antibody Testing. I voluntarily consent to the withdrawal of blood, urine, or oral fluid, the testing 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)

State of Residence

Signature of Proposed Insured

Date



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State of Residence

Signature of Proposed Insured

Date

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to CUNA Mutual Life Insurance Company. Therefore, CUNA Mutual Life Insurance Company makes no representations or warranties that this information is accurate as of the date you receive this list. Also, CUNA Mutual Life Insurance Company makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE - U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM
Fresno
(209) 264-2436

AIDS PROJECT - EASY BAY - Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION - Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 864-5855

SANTA CLARA COUNTY ARIS PROJECT - Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE - So. California
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF SO. CA.
Social Services - So. California
Hemophilia AIDS Information
(818) 793-6192
(714) 740-2222

**CALIFORNIA DEPARTMENT OF HEALTH
SERVICES - Statewide Services**
Office of AIDS, Sacramento
(916) 323-7415

**AIDS SERVICES FOUNDATION OF
ORANGE COUNTY - Costa Mesa**
(714) 646-0411

AIDS PROJECT - LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San Diego
(619) 945-6000 - City of Vista

**SANTA BARBARA COUNTY AIDS
INFORMATION HOTLINE**
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252