

EMPIRE GENERAL LIFE ASSURANCE CORPORATION

Statements Made to Medical Examiner

P. O. Box 310
Shawnee Mission, KS 66201

(PLEASE PRINT) Proposed Insured _____		Birth Date _____	
First Name	Middle Initial	Last Name	
1. a. Name and address of your personal physician? (If none, check box) <input type="checkbox"/> None _____			
b. Date and reason last consulted? _____			
c. What treatment was given or medication prescribed? _____			
2. Within the last twelve months, have you:		8. Have you ever requested or received a pension, or payment because of an injury, sickness or disability? Yes No	
a. Smoked a cigarette?	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
b. Used tobacco in any other form?	<input type="checkbox"/> <input type="checkbox"/>	9. Do you participate in a regular, supervised exercise program, or any organized sport? <input type="checkbox"/> <input type="checkbox"/>	
3. Have you ever had, been told you had, or been treated for:		10. Do you know if any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure, Diabetes, or committed suicide? (Please show age at onset and/or date of death). <input type="checkbox"/> <input type="checkbox"/>	
a. Chest pain, pulse irregularity, high blood pressure, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	<input type="checkbox"/> <input type="checkbox"/>	11. 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.)	
b. Cancer, tumor, or disorders of lymph glands?	<input type="checkbox"/> <input type="checkbox"/>		
c. Diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/> <input type="checkbox"/>		
d. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?	<input type="checkbox"/> <input type="checkbox"/>		
e. Jaundice, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis, or other disorder of the stomach, intestines, liver or gallbladder?	<input type="checkbox"/> <input type="checkbox"/>		
f. Blood spitting, asthma, emphysema, bronchitis, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/> <input type="checkbox"/>		
g. Convulsions, seizures, epilepsy, paralysis, mental or nervous disorder?	<input type="checkbox"/> <input type="checkbox"/>		
h. Anemia, or other disorder of the blood, or immune system?	<input type="checkbox"/> <input type="checkbox"/>		
i. Rheumatism, arthritis, gout, or disorder of the muscles, bones or joints, including the spine?	<input type="checkbox"/> <input type="checkbox"/>		
j. Deformity, or amputation?	<input type="checkbox"/> <input type="checkbox"/>		
4. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)? <input type="checkbox"/> <input type="checkbox"/>			
5. Other than above, have you within the past 5 years:			
a. Had a checkup, consultation, illness, injury, 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, other diagnostic test?	<input type="checkbox"/> <input type="checkbox"/>		
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/> <input type="checkbox"/>		
e. Had any mental or physical disorder not listed above?	<input type="checkbox"/> <input type="checkbox"/>		
6. a. Are you now under medical treatment or observation? <input type="checkbox"/> <input type="checkbox"/>			
b. Has your weight changed in the past year?			
Gain	lbs. Loss	lbs.	
7. a. Have you ever been advised by a physician that your use of alcohol or drugs was sufficient to impair or possibly impair your health? <input type="checkbox"/> <input type="checkbox"/>			
b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction? <input type="checkbox"/> <input type="checkbox"/>			
c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program? <input type="checkbox"/> <input type="checkbox"/>			
d. Have you ever been treated for alcohol or drug use? <input type="checkbox"/> <input type="checkbox"/>			
e. Do you or have you ever smoked marijuana? <input type="checkbox"/> <input type="checkbox"/>			
f. Do you or have you ever used cocaine? <input type="checkbox"/> <input type="checkbox"/>			

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Signed at _____, _____ State Date: _____
City or Town

Witness _____ (X) _____
Medical Examiner Signature of person proposed for insurance if age 15 or over, or Parent if proposed insured is under age 15.

MEDICAL EXAMINER'S REPORT

12. a. Height _____ ft. _____ in.
 Weight _____ lbs.

b. Did you weigh and measure applicant? Yes No

Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
in.	in.	in.

Applicant's Identity was established by:

Drivers License # _____

Social Security # _____

Other _____

13. Blood Pressure: (Record all readings) (If Above 140/90 Record Additional Readings.)

	1st	2nd	3rd
Systolic			
Diastolic (5th phase)			

14. Pulse: Exercise if irregular, over 90 or less than 50 per min.

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

Details of Positive Findings

15. Heart: Is there any:

Enlargement Yes No Dyspnea Yes No

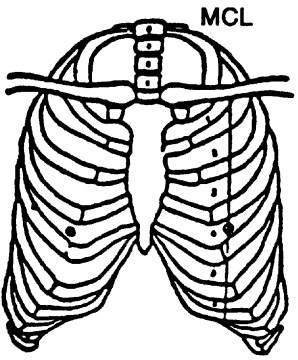
Murmur(s) Yes No Edema Yes No

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

	Murmur 1.	Murmur 2.
Location		
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
- Murmur area by
- Point of greatest intensity by
- Transmission by



For comments and your impression?

16. 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; 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?	<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"/>

17. Are you aware of or do you suspect any other medical, alcoholic or drug history? (If yes, please send a confidential report to the Medical Director) Yes No

18. Urinalysis: Albumin _____ Sugar _____ Specific Gravity _____
 In Addition To Performing Above Urinalysis, Please Send Specimen To Lab On ALL Exams.

19. If required, was Blood Sample sent to Lab: Yes No
 If required, was the following sent to the Home Office: EKG Yes No Stress Test Yes No X-Ray Yes No

I certify that I have made this examination with the results recorded on this _____ day of _____, 19 _____

Examination was made at: My Office Applicant's residence Applicant's place of business

Person Examined is: Not My Patient My Patient (If patient, please send copies of charts)

_____, M.D.
 Signature of Medical Examiner
 (Print, type or rubber stamp name of examiner and office address below)
 Name _____
 Address _____
 City, State & Zip _____

1. Name of agent requesting exam _____
 2. Name of person examined _____
 Address _____
 City, State & Zip _____

(EXAMINATION NOT TO BE GIVEN TO AGENT)

EMPIRE GENERAL LIFE ASSURANCE CORPORATION

P.O. Box 310 • Shawnee Mission, KS 66201

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above, Empire General Life Assurance Corporation, has requested that you provide a 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 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 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.

Consent

I have read and I understand this Notice and consent for AIDS-Related Testing. I voluntarily consent to the withdrawal of blood, urine, or saliva from me, the testing of that blood, urine, or saliva, 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.

Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

Name of Proposed Insured

Address