

**PART II of an application for insurance to the:** \_\_\_\_\_

(name of company)

**PROPOSED INSURED:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Male  
 Female

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

2. Have you ever been treated for or ever had any known indication of:
 

a. Disorder of eyes, ears, nose or throat?	Yes	No	
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 disorder?	<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"/>	
l. Excessive use of alcohol, tobacco or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you now under observation or taking treatment?  Yes  No
4. Have you had any change in weight in the past year?  Yes  No
5. Other than above, have you within the past 5 years:
 

a. Had any mental or physical disorder not listed above?	Yes	No	
b. Had a checkup, consultation, illness, injury, or 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 an electrocardiogram, X-ray, or 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"/>	
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?  Yes  No
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?  Yes  No
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?  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.)

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

9. Females only:
 

	Yes	No	
a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	
b. To the best of your knowledge and belief, are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

I HEREBY DECLARE that, to the best of my knowledge and belief, the statements and answers in Part II of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

Signature of Witness \_\_\_\_\_

Signature of PROPOSED INSURED \_\_\_\_\_

Signed at: (City & State) \_\_\_\_\_

On \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize any 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 records or knowledge of me or my health, to give to the \_\_\_\_\_ Life Insurance Company any such information.  
To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photographic copy of this authorization shall be as valid as the original.

Date \_\_\_\_\_

Signature of PROPOSED INSURED \_\_\_\_\_

**PART III – PARAMEDICAL REPORT**

NAME OF PERSON EXAMINED (PRINT)

DOB \_\_\_\_\_

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First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

1. A. Have you smoked cigarettes in the past 10 years?  Yes  No
- B. Are you using tobacco in any other form? If yes, specify \_\_\_\_\_?  Yes  No
- C. Present cigarette smokers:  
 (1) How many cigarettes do you smoke per day? (Number of cigarettes not number of packs) \_\_\_\_\_  
 (2) How many years have you smoked? \_\_\_\_\_
- D. Past cigarette smokers:  
 (1) How many cigarettes did you smoke per day? (Number of cigarettes not number of packs) \_\_\_\_\_  
 (2) How many years did you smoke? \_\_\_\_\_  
 (3) When did you quit smoking? \_\_\_\_\_

2. A. Age at last birthday \_\_\_\_\_ years. B. Sex  Male  Female
- C. Does applicant appear stated age?  Yes  No If no, explain: \_\_\_\_\_

- D. Are there any obvious physical abnormalities?  Yes  No If yes, explain: \_\_\_\_\_

3. MEASUREMENTS (Estimated measurements are not acceptable.)
- A. Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in. B. Weight (clothed) \_\_\_\_\_ lbs
- C. For males only:  
 I. Chest circumference: full inspiration \_\_\_\_\_ in. forced expiration \_\_\_\_\_ in.  
 II. Abdomen at umbilicus \_\_\_\_\_ in.

4. BLOOD PRESSURE: Applicant to be sitting. Take pressure in both arms. If more than 10mm. difference, repeat in both arms; otherwise, repeat in either arm. If blood pressure is over 140/90, record additional readings, sitting after 15 minutes. Diastolic pressure to be noted at disappearance of sound (5<sup>th</sup> phase).

	Right Arm		Left Arm	
	Systolic	Diastolic	Systolic	Diastolic
1st Reading				
2nd Reading				
_____ Min. Later				
_____ Min. Later				

5. PULSE \_\_\_\_\_/min. (at rest) If over 90, repeat in 5-10 minutes and record \_\_\_\_\_/min.  
 Any irregularities?  Yes  No If yes, enter number per minute \_\_\_\_\_

6. A. URINALYSIS: Albumin \_\_\_\_\_ Sugar \_\_\_\_\_ Other \_\_\_\_\_  
 Is specimen being forwarded to Lab?  Yes  No Which Lab? \_\_\_\_\_
- B. Have any medications of any type been taken or administered in the past ten days?  Yes  No  
 If Yes, specify \_\_\_\_\_
- C. If female, is applicant menstruating on day of examination?  Yes  No If Yes, please arrange to collect specimen on another day when all flow has stopped.

7. OTHER STUDIES (if required by instructions from Home Office)
- A. Electrocardiogram attached  D. Hemoglobin \_\_\_\_\_ gms. % or Hemocrit \_\_\_\_\_ %  
 B. Chest X-ray  E. Others (specify): \_\_\_\_\_  
 C. Vital capacity \_\_\_\_\_ Liters 1 second \_\_\_\_\_ Liters

I certify that I personally asked each and every question on the Part B – and accurately recorded the answers thereon. I personally performed the physical measurements and observations recorded on this page.

Date of Examination \_\_\_\_\_ (Signature of person completing form) \_\_\_\_\_

PARAMEDICAL FIRM NAME AND ADDRESS (PRINT OR STAMP)

**Examination Management Services, Inc.**

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 Paramed