

**Application Part 2 To:**  **THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES**  
 **EQUITABLE VARIABLE LIFE INSURANCE COMPANY**  
 **THE EQUITABLE OF COLORADO, INC.**

**PARAMEDICAL**

Reason for submission of this form:  New Policy  Policy Change  Reinstatement

1. **a.** Proposed Insured (Please Print) First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
**b.** Height: \_\_\_\_ ft. \_\_\_\_ in. **c.** Weight: \_\_\_\_ lbs.  
**d.** Birth Date: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_  
**e.**  Male  Female

2. **a.** Name and address of personal physician (or medical facility used instead): (If none, so state) \_\_\_\_\_

**b.** Date and reason last consulted if within the last 5 years: \_\_\_\_\_

**c.** What treatment was given or recommended? (If none, so state) \_\_\_\_\_

(For all "Yes" answers to Questions 3-9, circle items that apply.)

3. Has Proposed Insured ever had or been treated for: **Yes No**

**a.** Disease or disorder of eyes, ears, nose or throat?

**b.** Dizziness, fainting, convulsions; paralysis or stroke; psychiatric, psychological or emotional disturbance; mental or nervous disease or disorder?

**c.** Shortness of breath; blood spitting; bronchitis, asthma, emphysema, tuberculosis or other chronic respiratory disease or disorder?

**d.** Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?

**e.** Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gallbladder?

**f.** Sugar, albumin, blood or pus in urine; stone or other disease or disorder of kidney or bladder?

**g.** Diabetes; cyst, tumor, or cancer; thyroid or glandular disorder; skin disease or disorder?

**h.** Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back, or joints?

**i.** Deformity, lameness or amputation?

**j.** Allergies; anemia; other blood or lymph disease or disorder?

**k.** Disorder of prostate, reproductive organs, breasts, menstruation or pregnancy?

4. Is Proposed Insured now under observation or taking treatment?

5. Has Proposed Insured, within the last 10 years, been:

**a.** Diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

**b.** Treated by a member of the medical profession for AIDS or ARC?

6. Has Proposed Insured, within the last 10 years:

**a.** Used, except as legally prescribed by a physician, tranquilizers; barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances?

**b.** Received counseling or treatment regarding the use of alcohol or drugs?

7. Has Proposed Insured's weight changed by more than 10 pounds in the last 6 months?

8. Other than as stated in answers to Questions 2-6, has Proposed Insured within the last 5 years: **Yes No**

**a.** Consulted or been examined or treated by any physician or practitioner?

**b.** Had any illness, injury, or surgery?

**c.** Been a patient in or been examined or treated at a hospital, clinic, sanatorium, or other medical facility?

**d.** Had electrocardiogram, X-ray, other diagnostic test?

**e.** Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?

9. Has Proposed Insured, within the last 12 months:

**a.** Smoked cigarettes?

**b.** Used any other form of tobacco? (Give full details.)

10. Family History:	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers/Sisters			

DETAILS FOR "YES" ANSWERS. Include: **i.** Question Number. **ii.** Diagnosis and Treatment. **iii.** Results. **iv.** Dates and Duration. **v.** Names and Addresses of all attending physicians and medical facilities. (If additional space is needed, please attach a separate sheet, dated, signed and witnessed as below.)

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 for insurance or request for policy change or reinstatement, as the case may be. The Insurer may rely on them in acting on the application or making the policy change or reinstatement.

Dated at \_\_\_\_\_ on \_\_\_\_\_ 19\_\_\_\_ **X** \_\_\_\_\_  
city state Mo. Day Yr. Signature of Proposed Insured

Witness (Must be Examiner): \_\_\_\_\_

# PARAMEDICAL FEE AUTHORIZATIONS

(To be detached only by The Equitable)

Name of Examination Facility (Print or Stamp) \_\_\_\_\_

Name of Person Examined (Print) \_\_\_\_\_

Street Address \_\_\_\_\_

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

Date of Examination \_\_\_\_\_

City or Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

-   -     SSN   -       EIN

Examiner's Social Security No. or Employer's Tax Identification No. whichever is applicable. (The fee cannot be paid without your Social Security Number or Employer Identification Number, whichever is applicable. Your S.S.N. or E.I.N. is required for tax reporting purposes under the Internal Revenue Code. If you do not furnish this number, you may be subject to a fine imposed by the IRS.)

**Insurance Examination (20)** Fee \$ \_\_\_\_\_  
 If other tests were done, which were requested and authorized by Equitable, list below:  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_  
 \_\_\_\_\_ Fee \$ \_\_\_\_\_

**THE EQUITABLE WILL PAY UP TO \$40.00 FOR THIS EXAM. PLEASE INDICATE YOUR FEE ABOVE.**

Equitable Use Only	Account	X	Code
LIC at	Individual Life		01
ASU at	EVLICO (Not ELA)		02
	Individual Health		03
	Individual Annuity		05
APP #	Life Account (ELA)		06
	or		
	Medical		07
	DI		08
Pol. #	Regular Group		10
	ELAS of Colorado		20

Place Barcode Label Here

# PARAMEDICAL REPORT

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES  
EQUITABLE VARIABLE LIFE INSURANCE COMPANY  
THE EQUITABLE OF COLORADO, INC.

Place Barcode  
Label Here

11a. Height (Without shoes) \_\_\_\_\_ Ft. \_\_\_\_\_ In.  
 11b. Weight (Clothed) \_\_\_\_\_ lbs.  
 11c. Chest—Full Inspiration \_\_\_\_\_ in.  
 11d. Chest—Forced Expiration \_\_\_\_\_ in.  
 11e. Abdomen at Umbilicus \_\_\_\_\_ in.

11f. Did you weigh?  Yes  No  
 11g. Did you measure?  Yes  No

12. Blood pressure—Record 1st Reading. If Reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd Readings at 5 min. intervals.

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

13. Pulse Rate \_\_\_\_\_ per min.  
 Is it regular?  Yes  No  
 If "No", describe: \_\_\_\_\_

14. Did you observe any physical defects (including scars, deformities, amputations, paralysis, sight or hearing impairment, etc.)?  Yes  No  
 If "Yes", describe: \_\_\_\_\_

15. Urinalysis

	Neg.	Pos.	Amt.
Protein	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____

**In all cases, send specimen to the laboratory with completed identification slip.**

16. Is blood being sent to the laboratory?  Yes  No

I made the examination reported above

at \_\_\_\_\_ A.M. on \_\_\_\_\_ Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr.

**X**

(Examiner's  
Signature)

\_\_\_\_\_ P.M.  
 at \_\_\_\_\_ (No.) \_\_\_\_\_ (Street) \_\_\_\_\_ (City or Town) \_\_\_\_\_ (State)

What proof (photo-proof preferred) of Applicant's identity did you review?  Driver's License  Other (Specify: \_\_\_\_\_)

Did this proof include a photograph?  Yes  No

Are you related to the Applicant or Agent?  Yes  No

Name of Agent \_\_\_\_\_

Name of Facility (STAMP OR PRINT)		
No.	Street	
City	State	Zip Code

**IMPORTANT: This report is the property of The Equitable and must be mailed immediately to the Agency Operations Manager. It should not be given to any other person. Before mailing, please review entire report to make certain that every question is answered completely.**