

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. PLEASE PRINT names and addresses. The proposed insured must sign in the Examiner's presence. Examinations must be made in private.

1. Full name: 2. Date of birth: 3. For how much insurance are you applying? 4. Have you lost 15 or more pounds during past 12 months? If "yes," give amount and cause of weight loss and number of months at present weight. 5. When did a physician or practitioner last examine, advise or treat you? Name Date Address Reason for consultation: What tests were done? What were the results of tests? What recommendations were made?	6. Family History Age List Any Health Problems Date Of Onset Father Mother Brothers Sisters	LIVING			DEAD		
		Age	List Any Health Problems	Date Of Onset	Age At Death	Cause Of Death	Date Of Onset
7. Have you ever been refused any form of Life or Health insurance or reinstatement or renewal thereof or been offered a modified policy or one with an extra premium? (If "yes," give details.)							
8. Have you ever received compensation for sickness or injury or been deterred or discharged from military service for physical reasons? (If "yes," give details.)							

Give complete information regarding affirmative answers in questions 9 through 19 under "Details" below. Specify conditions, severity, date, duration, frequency of attacks, aftereffects, and name and address of each doctor and of each hospital.

	YES	NO	DETAILS
9. Have you ever been treated for alcoholism or any drug habit?	<input type="checkbox"/>	<input type="checkbox"/>	
10. In the past 5 years have you ever used: a. barbiturates, sedatives or tranquilizers without a medical prescription? b. L.S.D., marijuana, cocaine or other narcotic drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
11. In the past 10 years have you been in a hospital, clinic, or institution, for observation, diagnosis, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
12. In the past 10 years have you had an X-ray, electrocardiogram, blood studies, or other diagnostic tests? If "yes," include date and type of test and reason for test with results.	<input type="checkbox"/>	<input type="checkbox"/>	
13. To the best of your knowledge and belief have you ever had or been told that you had: a. dizziness, fainting spells, severe headaches, paralysis or stroke, epilepsy, mental illness or any brain or nervous system disorder? b. hepatitis, ulcer or any disorder of the lungs, stomach, intestines, rectum, liver, kidneys, glands or blood? c. high blood pressure, chest pain, rheumatic fever, heart murmur, or any disease or disorder of the heart or circulatory system? d. cancer, tumor, diabetes or sugar, albumin, blood or pus in the urine? e. arthritis, lupus erythematosus or any disorder of the back, bones, joints or muscles? f. genital or rectal warts, urethritis, chlamydia or any sexually transmitted disease? g. Have you ever received treatment for or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) by a member of the medical profession or tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	
14. In the past 5 years have you consulted or been treated or examined by any physician or practitioner a. not named above? or b. for any cause not recorded above?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you now any abnormality, deformity, disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Are you receiving treatment or taking medication of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Have you ever had or been told that you had any tumor or disease of the breast or other genital organs, menstrual irregularity or complications of pregnancy or any prostate disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
18. In the past 12 months, have you used tobacco in any form or any other nicotine dispensing products? If "yes," describe _____	<input type="checkbox"/>	<input type="checkbox"/>	
19. Have you used any of the above in the past and quit? If "yes," when? _____ What did you use? _____	<input type="checkbox"/>	<input type="checkbox"/>	

I hereby agree that the above questions and answers shall form a part of my pending application for insurance, and also of any subsequent application by me for insurance in this Company, unless I then undergo another medical examination which by its terms is made a part of such application and of subsequent applications.

Witness M. D. Date of Exam

Medical Examiner

.....
Signature of Proposed Insured

Make a very careful examination of heart and lungs with stethoscope. With some histories, positive or negative findings may have particular significance, and in such cases, comments regarding relevant findings should be included under "Details" below e.g., with heart murmur history, report heart findings appropriately.

1. Height in shoes ft. in. Weight without coat lbs.	Did you measure? Did you weigh?	3a. Pulse Seated	3b. Is pulse regular? If not, give the number of irregularities before and after exercise.									
2. Measurements Chest: forced in. forced expiration in. Abdomen in.		4. Blood Pressure. Please record all readings. With history of hypertension or if first reading is over 140 systolic or over 90 diastolic, take two additional readings at 2 minute intervals. <table style="width:100%; border: none;"> <tr> <td style="text-align: center;">First Reading</td> <td style="text-align: center;">All Subsequent Readings</td> <td style="text-align: center;">What Size Blood Pressure Cuff Was Used?</td> </tr> <tr> <td>Systolic</td> <td>.....</td> <td><input type="checkbox"/> Regular <input type="checkbox"/> Large</td> </tr> <tr> <td>Diastolic</td> <td>.....</td> <td></td> </tr> </table>		First Reading	All Subsequent Readings	What Size Blood Pressure Cuff Was Used?	Systolic	<input type="checkbox"/> Regular <input type="checkbox"/> Large	Diastolic	
First Reading	All Subsequent Readings	What Size Blood Pressure Cuff Was Used?										
Systolic	<input type="checkbox"/> Regular <input type="checkbox"/> Large										
Diastolic											

PHYSICIANS ONLY COMPLETE THIS SECTION

	YES	NO	
5. Do you find any evidence of past or present disease:			DETAILS
a. of the heart and blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a murmur? If "yes," give location, timing, intensity, transmission, characteristics, and effect of exercise.	<input type="checkbox"/>	<input type="checkbox"/>	
any hypertrophy? If "yes," give degree.	<input type="checkbox"/>	<input type="checkbox"/>	
any arteriosclerosis? If "yes," describe.	<input type="checkbox"/>	<input type="checkbox"/>	
b. of the lungs? Describe and give location.	<input type="checkbox"/>	<input type="checkbox"/>	
c. of any of the abdominal organs? Palpate for any areas of tenderness, masses, or enlargement of liver or spleen.	<input type="checkbox"/>	<input type="checkbox"/>	
d. of the skin, breasts, ears, eyes, throat?	<input type="checkbox"/>	<input type="checkbox"/>	
e. of the brain or nervous system? Test knee jerks and pupillary reactions.	<input type="checkbox"/>	<input type="checkbox"/>	
6. a. Is there any enlargement of thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Is it symmetrical, asymmetrical, nodular, diffuse?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Are the lymph nodes enlarged? If "yes," describe.	<input type="checkbox"/>	<input type="checkbox"/>	

PARAMEDICS & PHYSICIANS COMPLETE THIS SECTION

8. a. Does proposed insured use any device to aid in locomotion?	<input type="checkbox"/>	<input type="checkbox"/>
b. Does proposed insured seem alert, oriented to time and place?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is proposed insured able to recall medical history without hesitation or assistance?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is proposed insured lame, maimed, or deformed? Describe.	<input type="checkbox"/>	<input type="checkbox"/>
11. a. Does proposed insured appear older than stated? If "yes," give apparent age.	<input type="checkbox"/>	<input type="checkbox"/>
b. Does his/her appearance indicate any sign of disease, disorder, or impairment?	<input type="checkbox"/>	<input type="checkbox"/>
12. Were the circumstances under which you completed examination satisfactory?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you in any way related to proposed insured or agent? Which one and how related?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you aware of anything about the health, habits, environment, or mode of life of proposed insured which might unfavorably affect his/her insurability?	<input type="checkbox"/>	<input type="checkbox"/>
15. How long and how well have you known proposed insured?		

URINALYSIS MUST BE COMPLETED ON EVERY EXAMINATION

Specific gravity? Reaction?

Albumin? Test used?

Sugar? Test used?

SEND ALL SPECIMENS TO OUR APPROVED LABORATORIES

Have you mailed Specimen? Yes No

I certify that I have carefully examined and that the examination was made in private at my office residence of proposed insured place of business of proposed insured

Date of exam Time o'clock A.M. P.M.

Examined at (Town) (County) (State) (Medical Examiner) M.D.

N.B.—THIS EXAMINATION MUST BEAR DATE OF DAY WHEN ACTUALLY MADE AND UNDER NO CIRCUMSTANCES ANY OTHER. (P.O. Address of Medical Examiner)

If not a regular appointed Examiner of the Company, state where graduated Date of graduation

Names of companies for which you examine?

TO ANY MEDICAL PRACTITIONER, CLINIC, HOSPITAL OR MEDICAL FACILITY

I am making application for insurance to Erie Family Life Insurance Company. The Medical Department needs information more definite than I am able to give concerning your observations and treatment. Will you kindly furnish them your findings with dates, treatment and prognosis in order that they may be in a position to act on my application?

.....
Date

.....
Signature of Proposed Insured

STATEMENT OF ACCOUNT — DO NOT DETACH

ERIE FAMILY LIFE INSURANCE COMPANY, 100 ERIE INSURANCE PLACE, ERIE, PA 16530

Examination of DATE OF EXAM Fee \$

Address of Applicant

Agent Examiner (Please Print)

Send Fee to

TO THE EXAMINER

1. Do not deliver or reveal this report to any Agent of the Company.
2. Please mail this report directly to the Company at 100 Erie Insurance Place, Erie, PA 16530
3. Do not detach this statement.