Part Two Application to

ERIE FAMILY LIFE INSURANCE COMPANY

100 Erie Insurance Place
Erie, PA 16530

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	LIVING			DEAD		
	Age	List Any Health Problems	Date Of Onset	Age At Death	Cause Of Death	Date Of Onset
Father						
Mother						
Brothers						
Sisters						

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 deferred 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?	☐	☐	
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?	☐	☐	
11. In the past 10 years have you been in a hospital, clinic, or institution, for observation, diagnosis, operation or treatment?	☐	☐	
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.	☐	☐	
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 Aquired 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?	☐	☐	
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?	☐	☐	
15. Have you now any abnormality, deformity, disease or disorder?	☐	☐	
16. Are you receiving treatment or taking medication of any kind?	☐	☐	
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?	☐	☐	
18. In the past 12 months, have you used tobacco in any form or any other nicotine dispensing products? If "yes," describe.	☐	☐	
19. Have you used any of the above in the past and quit? If "yes," when? ________ What did you use? ________	☐	☐	

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

EFL-2101 7/94

DO NOT DETACH

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 ....

(OVER)

Part Three

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

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. Did you measure? ....
   Weight without coat .... lbs. Did you weigh? ....
2. Measurements (Males Only)
   Chest: forced inspiration .... in. forced expiration .... in.
   Abdomen .... in.

3a. Pulse Seated

3b. Is pulse regular? If not, give the number of irregularities before and after exercise.

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.

	First Reading	All Subsequent Readings
Systolic	....	....
Diastolic		

What Size Blood Pressure Cuff Was Used? ☐ Regular ☐ Large

PHYSICIANS ONLY COMPLETE THIS SECTION

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

PARAMEDICS & PHYSICIANS COMPLETE THIS SECTION

	YES	NO
8. a. Does proposed insured use any device to aid in locomotion?	☐	☐
b. Does proposed insured seem alert, oriented to time and place?	☐	☐
9. Is proposed insured able to recall medical history without hesitation or assistance?	☐	☐
10. Is proposed insured lame, maimed, or deformed? Describe.	☐	☐
11. a. Does proposed insured appear older than stated? If "yes," give apparent age.	☐	☐
b. Does his/her appearance indicate good health?	☐	☐
12. Were the circumstances under which you completed examination satisfactory?	☐	☐
13. Are you in any way related to proposed insured or agent? Which one and how related?	☐	☐
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?	☐	☐
15. How long and how well have you known proposed insured?		

DETAILS

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) .... M.D. (Medical Examiner)

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 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.