

Send to: Family Life Insurance Company
P.O. Box 149138
Austin, TX 78714-9138

FAMILY LIFE
INSURANCE COMPANY

PART II STATEMENT MADE TO MEDICAL EXAMINER

1. Have you had a physical check-up or health examination within the past three years? → If "YES" complete the following: ← Did any symptoms prompt this examination? Was any prescription or advice received? Give details below, including doctor's name, address and date of latest examination. _____	Yes	No	2. Height _____ Ft. _____ In.		Weight _____ lbs.	
			3. Family record		Age if living	Age at death
			Father			Cause of death or current health status
			Mother			
		Brothers _____				
		Sisters _____				
4. When and for what purpose did you last consult a doctor or other medical practitioner? _____ _____ Name and address _____						
5. Have you ever had or been told you had: (IF "YES" ENCIRCLE ITEM AND GIVE DETAILS—IDENTIFY BY QUESTION NUMBER AND LETTER) For conditions marked with (*) please submit home office specimen.						
a. Pneumatic fever, heart murmur, heart disease or disorder, chest pain, high blood pressure*, anemia or other disorder of the blood or circulatory system?	Yes []	No []	Doctor's name and address, dates, number of attacks, duration, etc. _____			
b. Paralysis*, dizziness, chronic headaches or any allergy?	[]	[]	_____			
c. Kidney disease*, blood in urine*, stones or gravel*, syphilis*, prostate* or other genito-urinary disorder*?	[]	[]	_____			
d. Diabetes*, sugar in urine*, thyroid disorder, arthritis, gout*, cancer, tumor or skin growth?	[]	[]	_____			
e. Asthma, pleurisy*, bronchitis, tuberculosis* or emphysema?	[]	[]	_____			
f. Gall bladder, liver, digestive or bowel disorder, ulcer or hernia?	[]	[]	_____			
g. Convulsion, epilepsy, stroke, loss of consciousness, nervous breakdown, emotional illness, eye disease or disorder of the ear, brain or nervous system?	[]	[]	_____			
h. Bone, joint or spinal disorder, back or neck pain?	[]	[]	_____			
i. AIDS or evidence of any immune system deficiency?	[]	[]	_____			
6. Have you ever had consultation, medical advice, treatment or hospitalization concerning your use of alcohol or drugs or have you ever used drugs habitually?	[]	[]	_____			
7. Any weight loss in past year? If yes, state number of pounds and how and why lost.	[]	[]	_____			
8. a. Have you ever had or been told you had a breast disorder or disease or surgery of the reproductive organs?	[]	[]	_____			
b. Is applicant pregnant? State month	[]	[]	_____			
9. Within the past five years, have you:	Yes	No	_____			
a. Been hospitalized for any reason?	[]	[]	_____			
b. Had an electrocardiogram (EKG), X ray, or blood study?	[]	[]	_____			
c. Any other consultations with doctors or other medical practitioners for any other physical or mental impairment, illness, injury or operation not otherwise listed? If "YES," give details, including dates, names and addresses, etc.			_____			

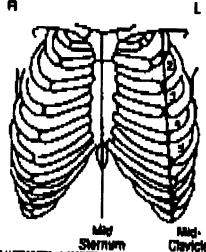
I have read the foregoing and represent that my above answers are COMPLETE and TRUE to the best of my knowledge and belief and agree that they shall constitute a part

PART III

FAMILY LIFE
INSURANCE COMPANY

Seattle, WA 98121

Please DO NOT Make Any Comments to the Applicant
Regarding Your Interpretation of His Insurability

1. Name of Applicant _____ Address _____ City _____ Sex: M _____ F _____ Birth Month _____ Day _____ Year _____		3. A. Does Applicant smoke cigarettes? YES [] NO [] B. Does Applicant use tobacco products in any form? YES [] NO []													
2. CARDIOVASCULAR EXAMINATION A. Blood Pressure (All readings to be taken in sitting position. If first reading over 140/90 make two additional observations at intervals. Send urine specimen to Home Office in all cases of blood pressure elevation.)		4. Measurements: Height _____ ft. _____ in. Weight _____ lbs. Did you measure? YES [] NO [] Did you weigh? YES [] NO [] Chest: full inspiration _____ in., forced expiration _____ in. Abdomen: at umbilicus _____ in.													
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 40%;">Systolic</th> <th style="width: 50%;">Diastolic (fifth phase)</th> </tr> </thead> <tbody> <tr> <td>1st reading</td> <td></td> <td></td> </tr> <tr> <td>2nd reading</td> <td></td> <td></td> </tr> <tr> <td>3rd reading</td> <td></td> <td></td> </tr> </tbody> </table>			Systolic	Diastolic (fifth phase)	1st reading			2nd reading			3rd reading			5. HERNIA Is There a Hernia? YES [] NO [] Reducible? YES [] NO [] Type of Hernia? _____	
	Systolic	Diastolic (fifth phase)													
1st reading															
2nd reading															
3rd reading															
B. PULSE RATE (Do Not Exercise if Contraindicated). Effort must result in pulse rate of at least 100		IF ANSWERS TO ANY OF QUESTIONS 5 & 6 ARE "YES" GIVE FULL DETAILS BELOW:													
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 20%;">Before exercise</th> <th style="width: 20%;">Immediately after</th> <th style="width: 20%;">3 minutes after</th> </tr> </thead> <tbody> <tr> <td>Pulse rate</td> <td></td> <td></td> <td></td> </tr> <tr> <td>No. irregularities of pulse/minute</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Before exercise	Immediately after	3 minutes after	Pulse rate				No. irregularities of pulse/minute				6. Do you find any abnormalities or evidence of past or present disease of: YES NO A. Brain or Nervous System? [] [] (Test reflexes, knee jerks, pupils and Romberg Test.) B. Lungs or other parts of the Respiratory System? [] [] C. Stomach or other Abdominal Organs? [] [] (Give details regarding any enlargement, tenderness, etc. of the spleen or liver.) D. Genito-Urinary System? [] [] E. Ears, Eyes, Nose or Throat? [] [] (If person is deaf, indicate if hearing aid if worn or speech is affected.) F. Endocrine System? [] [] (Give details regarding any thyroid enlargement, e.g. type, size and extent. If hyperthyroidism is involved give details as to effect on other systems.) G. Bones, Joints, Glands or Skin? [] [] H. Any other part of the body? [] []	
	Before exercise	Immediately after	3 minutes after												
Pulse rate															
No. irregularities of pulse/minute															
C. HEART EXAMINATION (Space for additional details below). 1. Degree of hypertrophy: [] None [] Slight [] Moderate [] Marked		2. Any evidence of decompensation? YES [] NO []													
3. Is there a murmur? YES [] NO [] →If "YES" furnish the following information:← a. Location [] Mitral [] Aortic [] Pulmonic b. Timing [] Systolic [] Presystolic [] Diastolic c. Intensity [] Faint [] Moderate [] Loud d. Quality [] Soft [] Blowing [] Rough		7. Is there any paralysis, deformity, lameness or loss of limb? YES NO [] []													
e. How is murmur affected by: Respiration? _____ Exercise? _____ Recumbency? _____		8. URINALYSIS (If there is any abnormality of the urine, history of urinary impairment within the last year or if applicant is over age 60, send portion of original specimen to Home Office). Are you satisfied the specimen is authentic? YES NO [] [] Specific gravity _____ Albumin _____ Sugar _____													
f. Is murmur transmitted? YES [] NO [] Where? _____		ARE YOU SENDING A SPECIMEN TO HOME OFFICE? YES NO [] []													
g. What is your diagnosis of the lesion? _____		9. Blood Study—If you have been requested to have Applicant submit a blood sample, please draw venous blood and carefully read blood kit instructions. If any questions, please call Home Office Reference Laboratory (913) 888-1770. ARE YOU SENDING A BLOOD SAMPLE? YES NO [] []													
4. Is there a thrill? YES [] NO []															
5. LOCATE ON CHART Apex by X Area of murmur by ○ Point of greatest intensity by ○ Transmission direction by →		Space for Details and Remarks—Identify by Question Number _____ _____ _____ _____													

I certify that I have carefully examined the above Applicant, in private, and not in the presence of any other person except as stated in the space above, that I have asked each question exactly as set forth on Part II of this form and that the answers thereto are in my handwriting and are exactly as made to me, and that they have been signed in my presence.

Examined at: [] APPLICANT'S RESIDENCE, [] MY OFFICE or [] OTHER (explain above) on _____ at _____ o'clock (a.m.) (p.m.)
 MONTH DAY YEAR

- Family Life Insurance Company
- Investors Life Insurance Company of North America

P.O. Box 149138 • Austin, TX 78714-9138 • 1-800-925-6000 • www.familylifeins.com • www.investorslife.com

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions will be based on the test result.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as required or allowed by law.

MEANING OF POSITIVE TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at increased risk of developing AIDS or AIDS-related conditions. The tests are tests for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

NOTIFICATION OF TEST RESULTS

A positive test result will be disclosed to a physician you designate. Because a trained person should deliver that information so that you can understand clearly what the test results mean, please list your private physician so that we can have him or her tell you the test results and explain their meaning.

I request that if the HIV antibody test result is positive, you report it to this physician:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. 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.

The results of these tests will be released to the physician you designate. The Department of Public Health will only be notified when mandated by state regulations.

Signature of
Proposed Insured
or Parent/Guardian _____ Date: _____