



CONTINUING MY APPLICATION TO FARM BUREAU LIFE INSURANCE COMPANY, WEST DES MOINES, IOWA

- ART TWO - STATEMENT TO MEDICAL EXAMINER

Proposed Insured: _____ Birth Date: _____
 First Name Middle Initial Last Name Month Day Year

1. A. Name and address of your personal physician? (If none, so state) _____
 B. Date and reason last consulted? _____ Treatment _____
 C. What treatment was given or medication prescribed? _____ Hospitalized? Yes No

2. Have you ever been treated for or been told you had:	YES	NO	Details of "Yes" answers. (Identify item)
A. Disorder of eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
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, chronic diarrhea, 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 disorders?.....	<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. Immune system disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
L. Allergies, recurrent infections, anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
M. Treated for alcoholism or any habit-forming drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	

3. Are you now under observation or taking treatment?.....
 4. Have you had any change in weight in the past year?.....

5. **Other than above**, have you within the past 5 years
 A. Had any mental or physical disorder not listed above?.....
 B. Had a checkup or consultation?.....
 C. Had an electrocardiogram or X-ray completed?.....
 D. Had blood studies or other diagnostic tests?.....
 E. Been advised to have any other diagnostic test, hospitalization or surgery?.....
 6. Used nicotine or tobacco in any form within the last 3 years?.....
 If "Yes": Current use: Form and amount/day _____
 Not current but within past 3 years:
 Date of most recent use: _____
 Form and amount/day: _____

7. Family History	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers/Sisters			

I DECLARE THAT MY ANSWERS TO THE FOREGOING QUESTIONS ARE FULL, COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT THEY SHALL FORM A PART OF MY APPLICATION.

Dated at _____ this _____ day of _____, _____.
 Witness to signature _____ Examiner
 Proposed Insured _____
 (If minor, parent or guardian signature)

432-010(07-98)

EXAMINER: PLEASE COMPLETE THIS SECTION

TO MEDICAL EXAMINERS
FARM BUREAU LIFE INSURANCE COMPANY
 This form must be completed by the Medical Examiner at the time of examination. The Company's check for payment will be forwarded promptly. **Only examination forms that are fully completed can be approved by the Medical Director.**
 Pay \$ _____ Date: _____
 Social Security/Tax Identification # _____ To: _____ Print Name
 Address: _____
 For medical examination of: _____ Print Name in Full
 Requisition for check covering medical examination fees approved by: _____

PART THREE - REPORT OF MEDICAL EXAMINER

MALES ONLY

Details of "Yes" answers. (Identify item)

8 A. Height (In shoes)	Weight (Clothed)		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
	ft.	in.	lbs.	in.	in.

B. Did you weigh? Yes No Did you measure? Yes No
 C. Is appearance unhealthy or older than stated age? Yes No

9. Blood pressure (Record ALL readings. If 140/90 or over, please take more than one reading.)

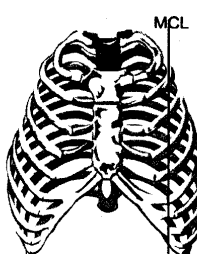
	1 st	2 nd	3 rd
Systolic			
Diastolic	4 th Place		
	5 th Place		

10. Pulse:	Rate	Irregularities per minute	11A. Heart: Is there any:
At rest			Dyspnea Yes <input type="checkbox"/> No <input type="checkbox"/>
After exercise			Edema Yes <input type="checkbox"/> No <input type="checkbox"/>
3 minutes later			Enlargement Yes <input type="checkbox"/> No <input type="checkbox"/>
			Murmur(s) Yes <input type="checkbox"/> No <input type="checkbox"/>

11B. (Describe murmurs below-if more than one, describe separately)

Locate 1 st Murmur	Locate 2 nd Murmur
Constant..... <input type="checkbox"/>	Constant..... <input type="checkbox"/>
Inconstant..... <input type="checkbox"/>	Inconstant..... <input type="checkbox"/>
Transmitted..... <input type="checkbox"/>	Transmitted..... <input type="checkbox"/>
Localized..... <input type="checkbox"/>	Localized..... <input type="checkbox"/>
Systolic..... <input type="checkbox"/>	Systolic..... <input type="checkbox"/>
Presystolic..... <input type="checkbox"/>	Presystolic..... <input type="checkbox"/>
Diastolic..... <input type="checkbox"/>	Diastolic..... <input type="checkbox"/>
Soft (Gr. 1-2)..... <input type="checkbox"/>	Soft (Gr. 1-2)..... <input type="checkbox"/>
Mod. (Gr. 3-4)..... <input type="checkbox"/>	Mod. (Gr. 3-4)..... <input type="checkbox"/>
Loud (Gr. 5-6)..... <input type="checkbox"/>	Loud (Gr. 5-6)..... <input type="checkbox"/>
After exercise:	After exercise:
Increased..... <input type="checkbox"/>	Increased..... <input type="checkbox"/>
Absent..... <input type="checkbox"/>	Absent..... <input type="checkbox"/>
Unchanged..... <input type="checkbox"/>	Unchanged..... <input type="checkbox"/>
Decreased..... <input type="checkbox"/>	Decreased..... <input type="checkbox"/>

Give location of apex beat by X.
 Indicate loudest point of murmur by O.
 Indicate area where heard by ●.
 Indicate direction of transmission by →.



Your diagnosis:

12. On examination, is there any abnormality of the following:
 (Circle applicable items and give details)

A. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	YES	NO
B. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
C. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
D. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
E. Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
F. Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
G. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
H. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

13. A. Are there any hernias?
 B. Any hemorrhoids?

14. Are you aware of additional medical history?

(A confidential report may be sent to the Medical Director.)

15. Urinalysis: Specific Gravity	Albumin	Sugar	Send specimen to our laboratory if:	4. Amount of insurance is over \$100,000;
			1. Urine is abnormal;	5. Applicant is over 60.
Is specimen being sent to our laboratory? Yes <input type="checkbox"/> No <input type="checkbox"/>			2. Any genito-urinary disturbance, past or present;	
			3. Applicant is pregnant;	

Examined at: (Indicate where) { Applicant's residence
 Applicant's business
 Examiner's office

Date: _____, at _____ (hour) A.M. P.M.

Medical Examiner: _____ Signature
 Name of Agent: _____

IMPORTANT

If the Examiner is aware of any additional information, he may record such information below. The information will be treated in confidence.

FOR HOME OFFICE USE

Signature of Medical Examiner