



Part Two — Statement To Medical Examiner

Continuing my application to Farm Family Life Insurance Company, Glenmont, New York

USE INK

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

1. a. Name and address of your personal Physician? _____
(If none, so state)
- b. Date and reason last consulted? _____
- c. What treatment was given or medication prescribed? _____

	Yes	No
2. Have you ever been treated for or ever had any know indication of:	<input type="checkbox"/>	<input type="checkbox"/>
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, 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. Allergies; anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>
m. Smoked cigarettes within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now under observation or taking treatment?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any change in weight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
5. Other than above, have you within the past 5 years:	<input type="checkbox"/>	<input type="checkbox"/>
a. Had any mental or physical disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a checkup, consultation, illness, injury, surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had electrocardiogram, X-ray, other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had military service, deferment, rejection or discharge because of a physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS OF "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS; include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities).

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brother and Sisters No. Living _____ No. Dead _____			

9. FEMALES ONLY:

a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? Yes No

b. To the best of your knowledge and belief are you now pregnant? Yes No

The above statement 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 and are made to induce the FARM FAMILY LIFE INSURANCE COMPANY to issue the policy or contract applied for.

Witnessed by Examiner _____ M.D. Date _____ (Month, Day, Year)

Signature of Proposed Insured _____

Part Three — Medical Examiner's Report

This examination should be made in private. If 3rd person present, give details.

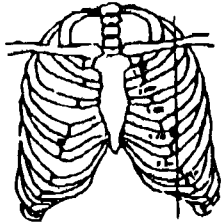
1. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, At Umbilicus Relaxed	
FT. IN.	LBS.	IN.	IN.	IN.	IN.

Details of "Yes" answers. (Identify item.)

- Did you weigh? Yes No Did you measure? Yes No
 Weight change in past year? lbs. Gain Loss · Cause? _____
 Is appearance unhealthy or older than stated age? Yes No
2. Blood Pressure (Record all readings). If more than 140/90, take two readings and an additional reading next day, please. If below 100/60, take additional reading after exercise and record.
- | | 1st | 2nd | 3rd (next day) |
|-------------------------|-----------|----------------|-----------------|
| Systolic | | | |
| Diastolic { | 4th phase | | |
| | 5th phase | | |
| 3. Pulse: | At Rest | After Exercise | 3 Minutes Later |
| Rate | | | |
| Irregularities Per Min. | | | |
4. Heart: (a) Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? Yes No
 (b) Is heart enlarged? Yes No (If yes, describe)
 (c) Is murmur present? Yes No (If yes, complete (4d))

- (d) Murmur is: Systolic Apical Soft (Gr. 1-2)
 Constant Transmitted Presystolic Basal Mod. (Gr. 3-4)
 Inconstant Localized Diastolic Other Loud (Gr. 5-8)
- After exercise: Unchanged Increased
 Decreased Absent

Show Location of:
 Apex by X
 Area of murmur by O
 Point of greatest intensity by O
 Transmission by —



Your impression?

5. Is there on examination any abnormality of the following:
 (Circle applicable items and give details.) Yes No
- | | | |
|---|--------------------------|--------------------------|
| (a) Eyes, ears, nose, mouth, pharynx
(If vision or hearing markedly impaired, indicate degree and correction.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins) | <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 (including 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"/> |
6. (a) Are there any herniae? Yes No
 (b) Any hemorrhoids? Yes No
7. Have you any pertinent information not brought out above? Yes No
8. Urinalysis: A specimen should be taken on all examinations. Please mail to the Labone, Shawnee Mission, Kansas in the mailer provided. Be sure the identification slip is properly completed.

I certify that I made this examination at A.M. P.M. on the _____ MONTH _____ DAY _____ YEAR

Examination made at my office, individual's office, individual's home, Other: _____

Examiner's signature: _____ Examiner's address: _____

MAIL THIS FORM TO:
 Farm Family Life Insurance Company · PO Box 656, Albany, NY 12201



VERMONT...

HIV TESTING INFORMATION STATEMENT & CONSENT FORM

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont Aids Hotline for information about free testing, the number is listed below) and any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the informed consent form any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;

2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to retest once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that retest.
3. If you are denied insurance because of a positive test result, you may request a retest once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such retest is negative, an insurer may not deny coverage based upon the initial test results.

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV antibodies.

Informed Consent

To be signed at the time when medical professional or company agent obtains sample

This statement has been read aloud to me and I understand this **HIV TESTING INFORMATION STATEMENT & CONSENT FORM**. I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured

Date

Birth date

State of Residence

Name of Medical Professional or Company Agent
Collecting Sample

Signature of Medical Professional or Company Agent

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO: :

Name

Address

City

State

Zip Code