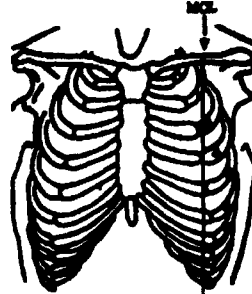






**PART III**

**MEDICAL EXAMINER'S REPORT**

15. a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	Details of "Yes" answers and any additional medical history or findings.
ft. in.	lbs.	in.	in.	in.	
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No					
16. Blood Pressure (Record ALL readings)			1st	2nd	3rd
Systolic					
Diastolic					
17. Pulse		At Rest	After Exercise	3 Minutes Later	
Rate					
Irregularities per min.					
18a. Heart: Is there any:					
Enlargement? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dyspnea? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Murmur(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Edema? <input type="checkbox"/> Yes <input type="checkbox"/> No			
(describe below – if more than one murmur, describe separately)					
Location					
Constant	<input type="checkbox"/>	<input type="checkbox"/>	<p>Indicate:</p> <p>Apex by <b>X</b></p> <p>Murmur Area by <b>○</b></p> <p>Point of greatest intensity by <b>○</b></p> <p>Transmission by <b>◊</b></p> 		
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>			
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>			
Localized	<input type="checkbox"/>	<input type="checkbox"/>			
Systolic	<input type="checkbox"/>	<input type="checkbox"/>			
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>			
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>			
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>			
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>			
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>			
After Exercise:			For comments and your impression.		
Increased	<input type="checkbox"/>	<input type="checkbox"/>			
Absent	<input type="checkbox"/>	<input type="checkbox"/>			
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>			
Decreased	<input type="checkbox"/>	<input type="checkbox"/>			
18b. Respiratory System: Are there any:					Yes    No
a. Abnormalities?					<input type="checkbox"/> <input type="checkbox"/>
b. If Yes, please describe:					
19. Are there, upon examination, any abnormalities of the following: (Circle applicable items and give details.)					Yes    No
a. Eyes, ears, nose, mouth, pharynx, skin? (If vision or hearing markedly impaired, indicate degree and correction.)					<input type="checkbox"/> <input type="checkbox"/>
b. Lymph nodes?					<input type="checkbox"/> <input type="checkbox"/>
c. Nervous system (Include reflexes, gait, paralysis)?					<input type="checkbox"/> <input type="checkbox"/>
d. Abdomen (Include scars)?					<input type="checkbox"/> <input type="checkbox"/>
e. Musculoskeletal system (Include spine, joints, amputations, deformities)?					<input type="checkbox"/> <input type="checkbox"/>

(See Reserve Side)

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**VOUCHER FOR PAYMENT OF EXAMINATION FEE**

Fees for Medical Examinations are paid monthly by check from the Home Office. DO NOT ACCEPT PAYMENT FROM ANY OTHER SOURCE.

This voucher will be returned to you with the Company's check and will serve as a record of the fee paid.

Record this examination in your day-book and if payment is not received within 60 days please notify the Medical Department.

20. Upon questioning, are there:		Yes	No	Details of "Yes" answers and any additional medical history or findings.
a. Any hemias?		<input type="checkbox"/>	<input type="checkbox"/>	
b. Any hemorrhoids?		<input type="checkbox"/>	<input type="checkbox"/>	
21. Are you this client's regular physician?		<input type="checkbox"/>	<input type="checkbox"/>	
Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)		<input type="checkbox"/>	<input type="checkbox"/>	
22. Urinalysis: (Always required)	Albumin	Sugar	*Send specimen to Home Office Reference Laboratory, Shawnee Mission, KS if: (1) Amount applied for is \$100,000 or over (2) There is previous or current urinary abnormality, diabetes, or elevated blood pressure. (3) Client is currently pregnant.	
Specific Gravity				
Is additional specimen being sent to H.O. Ref. Lab (Kansas)**?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

I certify that the above is a record of a careful examination of the Proposed Insured and that I faithfully recorded the answers on Part II of the application before the signature of the Proposed Insured was affixed thereto. Examination made at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. on (Date) \_\_\_\_\_

at  My office  Proposed Insured's Home  Proposed Insured's place of business in:  
 City and State \_\_\_\_\_  
 Where graduated \_\_\_\_\_  
 Date of graduation \_\_\_\_\_  
 Signature of Examiner \_\_\_\_\_  
 Physician  Paramedic

Office Address: Street & No. \_\_\_\_\_  
 City, State, & Zip Code \_\_\_\_\_

Review report carefully for completeness of all sections, then mail directly, without exception, to the Medical Director at the Home Office.  
 COMPLETE VOUCHER BELOW - DO NOT DETACH.

-----  
 PLEASE PRINT - DO NOT DETACH  
 Client's Name \_\_\_\_\_ Examiner's Name \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City and State \_\_\_\_\_  
 Date of examination \_\_\_\_\_  
 Paramedic  Physician  
 Name of Marketing Representative who requested you to make this examination \_\_\_\_\_  
**FEDERATED LIFE INSURANCE COMPANY**  
 121 East Park Square  
 P.O. Box 328  
 OWATONNA, MINNESOTA 55060

**CALIFORNIA NOTICE OF AIDS VIRUS ANTIBODY TESTING  
AND AUTHORIZATION FOR TESTING AND DISCLOSURE**

Federated Life Insurance Company  
121 East Park Square, P.O. Box 328  
Owatonna, MN 55060

To determine your insurability, the insurer named above has requested a sample of your blood for testing and analysis. One of the tests to be performed will be to determine the presence or absence of antibodies to the HIV virus. Antibodies to the HIV virus are produced by the body when it has been infected by the HIV virus. Antibodies are the body's way of fighting the infection. This is not a test for AIDS. It is a test for antibodies to the HIV virus which causes AIDS, and shows whether you have been exposed to the virus. The HIV antibody test is actually a series of tests. These tests are extremely reliable. Your blood sample is first subjected to an ELISA (enzyme-linked immunosorbent assay) test. If the test is positive, a second ELISA test is performed. If the second test is positive, a Western Blot Test is performed. Your test result is considered positive only after positive results are obtained on all three tests.

A negative test result indicates that the antibody has not been found in your blood. If you test negative there are three possible explanations:

- You have not been infected with the virus; or
- You have had contact with the virus but have not become infected; or
- You have been infected by the virus but have not yet produced antibodies.

Research indicates that most people produce antibodies within 2 - 8 weeks after infection. A very small number of people will never produce antibodies.

A negative result does not mean:

- That you are immune to the virus;
- That you have not been infected with the virus. You may have been infected and have not yet produced antibodies.

A positive test result indicates that you have probably been infected with the AIDS virus and your body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. You may therefore assume you are contagious and capable of passing the virus to others. A positive test does not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. A positive test does not mean that you are immune to AIDS.

Normal test results will not affect your eligibility for insurance. A positive HIV antibody test will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

All test results will be treated confidentially. They will be reported to the Insurer by the laboratory. Negative test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific blood abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you.

Public health authorities say that persons who are HIV antibody positive should be considered infected and capable of infecting others. Health authorities urge that everyone become educated about how to protect themselves from HIV infection. The virus is spread by sexual contact, needle sharing, or, rarely, through transfused blood or its components. The risk of infection with the virus is increased in drug users who share needles and in individuals with multiple sexual partners, either homosexual or heterosexual.

Most individuals infected with the virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever, including "night sweats"
- Weight loss for no apparent reason
- Swollen lymph glands in the neck, underarm or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth

These symptoms are also symptoms of many other illnesses. They may be symptoms of the virus only if they are unexplained by other illnesses. People who are infected remain infected indefinitely and can pass the virus to others. Only a doctor and a blood test can tell if someone is infected with HIV, the virus that causes AIDS.

### NOTIFICATION OF TEST RESULTS

If your test results are positive or indeterminate, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, we ask that you give us the complete name and address of your physician. If your test results are positive and you have chosen not to authorize a physician to receive the test results, we encourage you to contact a physician, the county department of health, the State Department of Health Services, local medical societies or alternative test sites for appropriate counseling. If your test results are normal, no routine notification will be sent to you.

Name and address of person physician: \_\_\_\_\_

### INFORMED CONSENT

I have read and understand this information statement. I voluntarily consent to have a blood sample taken. I consent to testing of that blood. I authorize the disclosure of the test results as described above.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Birthdate

### LISTING OF CALIFORNIA AIDS COUNSELING RESOURCES

San Francisco AIDS Foundation  
25 Van Ness Avenue, Suite 660  
San Francisco, CA 94102  
(415) 864-5855

AIDS Services Foundation of Orange County  
1685-A Babcock Street  
Costa Mesa, CA 92627  
(714) 646-0411

Sacramento AIDS Foundation  
1900 K Street, Suite 201  
Sacramento, CA 95814  
(916) 448-2437

San Diego AIDS Project  
3777 Fourth Avenue  
San Diego, CA 92103  
(619) 543-0300

Central Valley AIDS Team  
P.O. Box 4840  
Fresno, CA 93744  
(209) 264-2436

AIDS Project - East Bay  
400 40th Street, Suite 20  
Oakland, CA 94609  
(415) 420-8181

AIDS Project Los Angeles  
3670 Wilshire Blvd., Suite 300  
Los Angeles, CA 90010  
(213) 380-2000

ARIS Project  
595 Millich Drive, Suite 104  
Campbell, CA 95008  
(408) 370-3272