

**PART 2 OF APPLICATION FOR INSURANCE**

Full Name of Proposed Insured:

First:

Middle Initial:

Last:

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1. Date of Birth (MM/DD/YY) / /

2. A. Name address and or phone number of your primary physician.

B. Date and reason for last consultation.

3. A. Have you applied for life or health insurance and been declined, postponed, rated or restricted in the last ten years? Yes  No   
 B. Have you been examined for insurance purposes in the past year or are you applying for insurance to any other company at this time? Yes  No   
 If Yes please provide names of companies, amounts and particulars in space for particulars.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 4. Have you ever been advised of, treated for, or had any known indication of:   |                          |                          |
| A. Disorder of eyes, ears, nose or throat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Dizziness, fainting, convulsions, epilepsy, headaches; 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, shortness of breath or other disorder of the heart or blood vessels?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, hepatitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder? | <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 (glandular) disorders?   | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Disorder of the spine, back, neck, joints, muscles, bones, nerves including neuritis, sciatica, rheumatism, arthritis or gout?  | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Deformity, lameness or amputation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Cancer, tumor, cyst or disorder of the skin or lymph glands?  | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Congenital disorder; allergies; anemia; leukemia; or other disorders of blood?  | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Alcoholism or excessive use of alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or AIDS related conditions or have you tested positive for antibodies to the human immunodeficiency virus (HIV)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever used marijuana, cocaine, heroin, narcotics, tranquilizers, or other mood altering drugs, except as prescribed by a physician?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other than above, within the past ten years have you:   |                          |                          |
| A. Had any mental or physical disorder?  | <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, or other diagnostic tests?  | <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"/> |



Initials Of Proposed Insured

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I agree that: (1) this application consists of Parts 1, 2, and 3 and any amendments and supplements which shall be attached to the policy if issued, and (2) no knowledge on the part of any producer, medical examiner or any other person as to any facts pertaining to me shall be considered as having been made to or brought to the knowledge of the Insurance Company, unless stated in either Parts 1, 2 or 3 of this application or by any amendments or supplements.

Anguilla law shall govern and control in the event of any conflict or dispute with regard to the policy. The parties submit themselves to the exclusive venue and jurisdiction of the courts of Anguilla for the resolution of any such conflict or dispute.

To the best of my knowledge and belief all answers and statements are full, complete and true and were correctly recorded before I signed my name below.

Name of Proposed Insured

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Signature of Proposed Insured

Date (MM/DD/YY) / /

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(Parent or legal guardian if Proposed Insured is under legal insuring age)

Name of Witness

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Signature of Witness

Date (MM/DDYY) / /

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**MEDICAL EXAMINER'S REPORT**

Full name of Proposed Insured

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**Examination to be made in private and this form to be completed by the medical examiner in his/her own handwriting.**

1. Date of Birth (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2. A. Height in shoes: \_\_\_\_\_ ft. \_\_\_\_\_ in.

B. Weight (clothed) \_\_\_\_\_ lbs.

C. Change in weight past 12 months: Gain \_\_\_\_\_ lbs. Loss \_\_\_\_\_ lbs

D. Explain any change and state how long at present weight.

\_\_\_\_\_  
\_\_\_\_\_

3. Blood Pressure (sitting) /

If first reading is over 140/90 make two additional observations.

Systolic			
Diastolic (fifth phase)			

4. Pulse: At Rest After Exercise 3 Minutes Later

Rate			
Irregularities per min.			

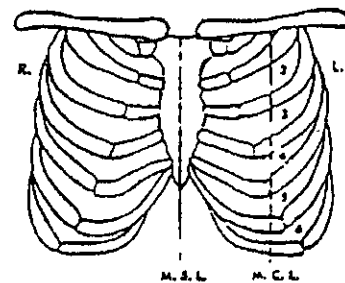
5. Heart:

Is there any  
 A. Enlargement  Yes  No  
 B. Murmur(s)  Yes  No  
 C. Dyspnea  Yes  No  
 D. Edema  Yes  No  
 (Describe below — if more than one, describe separately)

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

Indicate:

Apex by X  
 Murmur area by O  
 Point of greatest intensity by M



Based on the history and examination, what is your impression?

6. Is there on examination any abnormality of the following: (Circle applicable items and give details) Yes No
- A. Head; eyes; ears; nose; mouth; pharynx? (If vision or hearing markedly impaired, indicate degree and correction)
- B. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?
- C. Nervous system (include reflexes, gait, paralysis)?
- D. Lungs?
- E. Abdomen (include scars)?
- F. Genitourinary system?
- G. Endocrine system (include thyroid and breasts)?
- H. Musculoskeletal system (include spine, joints, amputations, deformities)?
7. A. Are there any hernias?
- B. Any hemorrhoids (by history or observation)?
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8. Are you aware of or do you suspect any other medical, alcoholic or drug history?    
(A confidential report may be sent to the Medical Director.)

9. A. Has blood chemistry profile been done?  Yes  No If yes send to Home Office Reference Laboratory(HORL).
- B. Has a urinalysis been done?  Yes  No If yes send to Home Office Reference Laboratory (HORL).

10. Do you know the Proposed Insured?  Yes  No Are you related?  Yes  No

11. Have you completed an EKG or Chest X-Ray on this applicant today?  EKG  Chest X-Ray  Stress EKG

Details of "yes" answers and supplementary remarks. Identify item.

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the history and examined the Proposed Insured in private, and witnessed his (or her) signature at

Proposed Insured's residence  Proposed Insured's place of business  My office

Other  \_\_\_\_\_

on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ at \_\_\_\_\_ o'clock . \_\_\_\_\_ M.D.

\_\_\_\_\_  
Signature of Medical Examiner