MEDICAL EXAMINER'S REPORT (continued)

6. To be completed if number 5h is answered "Yes" or if requested:

	YES	NO	REMARKS
a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)? .	☐	☐	
b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?	☐	☐	
c. Are there gallops (S3 or S4)?	☐	☐	
d. Is/are there ejection sound(s) or systolic click(s)?	☐	☐	
e. Is/are there murmur(s) present? If "Yes", fully describe under "Remarks" including timing (systolic or diastolic), intensity (grd. 1-6), location, transmission, or radiation.	☐	☐	
7. a. Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions?	☐	☐	
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age?	☐	☐	
8. a. Were you acquainted with the Proposed Insured prior to this examination? If "Yes", fully describe the relationship in "Remarks".	☐	☐	
b. Are you the proposed insured's personal physician?	☐	☐	
c. Was the examination conducted in a language other than English? If "Yes", indicate language used and provide name/address/relationship to proposed insured of person acting as interpreter.	☐	☐	

9. How did you identify the Proposed Insured? ☐ Driver's license ☐ Other ______________________

I hereby certify that I have personally examined ______________________
and have correctly and fully reported my findings. Name of Proposed Insured

Examined at ______________________, this ________ day of ______________, 19 _____,

at __________ AM/PM X ______________________ Examiner
Signature of Examiner ☐ Paramed ☐ MD

Print Examiner's Name ______________________

Examiner's phone no. (   ) ______________________

Paramed Company ______________________ Phone No. (   ) ______________________

Address ______________________

____

FIRST PENN-PACIFIC LIFE INSURANCE COMPANY

MEDICAL EXAMINER'S REPORT

Instructions to the Examiner —

This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to the Proposed Insured. Please weigh and measure this applicant. Explain all positive findings under "Remarks".

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form. If for any reason you do not care to give certain confidential information on this form, please record such information on a separate sheet and mail directly to the Medical Director of the Company.

1. **Height** (in shoes) ________ft. _________in.

   Weight (clothed) ______________ lbs.

   Measurements (males only)

   Chest (full inspiration) _______ in. Chest (forced expiration) ______in.

   Abdomen (at umbilicus) ______in.

2. **Blood Pressure** (if above 140/90 or if Proposed Insured has had hypertension, provide two additional readings taken at intervals.)

   Initial reading ______________________________

   Additional readings ______________________________

3. **Pulse** At rest _______________

   Describe any irregularities (No. per minute, etc.)

   ____

   ____

   ____

4. **Have you drawn a blood specimen and mailed it to the lab along with a urine specimen?** ☐ Yes ☐ No

   Indicate name of lab ______________________________

IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 5, 6, AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.

5. After physical examination and inquiry, do you find any abnormality of the following:

	YES	NO	REMARKS
a. Eyes, ears, nose, mouth, pharynx?	☐	☐	
b. Skin (incl. scars), thyroid, lymph nodes, veins, peripheral arteries?	☐	☐	
c. Brain, nervous system (include reflexes, gait, coordination, paralysis)?	☐	☐	
d. Respiratory system?	☐	☐	
e. Stomach, abdominal organs?	☐	☐	
f. Is the liver enlarged?	☐	☐	
g. Genitourinary system?	☐	☐	
h. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete Section 6.)	☐	☐	

PART TWO OF APPLICATION TO FIRST PENN-PACIFIC LIFE INSURANCE COMPANY

Executive Office: 10 North Martingale Road, Schaumburg, Illinois 60173-2268, (847) 466-8000

1. PROPOSED INSURED

Full name ______________________________ Date of Birth _____/_____/______ Social Security No. ______________

First M.I. Last Month Day Year

2. Have you ever had or ever been treated for: YES NO

a. High blood pressure, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? . . . ☐ ☐

b. Epilepsy, convulsions, fainting spell, stroke, paralysis, head injury, or other disease or disorder of the brain or nervous system? . . . ☐ ☐

c. Diabetes or any other disease or disorder of the pituitary, thyroid, or endocrine glands? . . . ☐ ☐

e. Cancer, tumor, leukemia, lymphoma, or any other malignant disorder? . . . ☐ ☐

f. Disorder or disease of the blood, including anemia, polycythemia, leukopenia, clotting disorder, immune disorder (congenital or acquired), or platelet disorder? . . . ☐ ☐

g. Cyst, polyp, lump, or other growth, or any disorder of the breast, skin, or lymph nodes? . . . ☐ ☐

h. Asthma, bronchitis, emphysema, pneumonia, sarcoidosis, sleep apnea, tuberculosis, shortness of breath, or other lung or respiratory ailment? . . . ☐ ☐

i. Hepatitis, ulcer, internal bleeding, colitis, or any other disease or disorder of the stomach, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? . . . ☐ ☐

j. Albumin, blood or sugar in the urine or any other disease or disorder of the kidney, bladder, prostate, or reproductive system? . . . ☐ ☐

k. Arthritis or any other disease or disorder of the muscles, connective tissues, or bones? . . . ☐ ☐

l. Anxiety, depression, or other mental or nervous disorder? . . . ☐ ☐

m. Any disease or disorder of the eyes, ears, nose, or throat? . . . ☐ ☐

3. a. Have you **ever** used any form of tobacco or nicotine-based products? . . . ☐ ☐

b. If "Yes", when did you last use tobacco or nicotine-based products? ______________ Month/ Year

Type ______________ Quantity ______________

4. Have you ever: YES NO

a. Used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, any derivative of these drugs, or any other controlled substance except as prescribed by a physician? . . . ☐ ☐

b. Received or been advised to receive treatment or counseling for alcohol or drug use by a physician, psychiatrist, or psychologist? . . . ☐ ☐

c. Been advised by a physician, psychiatrist, or psychologist to quit or reduce your alcohol use? . . . ☐ ☐

d. Been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)? . . . ☐ ☐

e. Been convicted of drug possession or distribution? . . . ☐ ☐

5. **Details of Items 2 through 4.** Give complete details of all "Yes" answers. Identify question number and include diagnoses, dates, durations, treatments and medications prescribed, and names/addresses of all physicians, psychiatrists, psychologists, and hospitals. *Use #13 on reverse side, if additional space needed.*

Question No.	

6. **Family Record**	Age(s) if Living	Age(s) at Death	Cause of Death
Father			
Mother			
Brothers and Sisters			

	YES	NO
7. Has any family member listed in Number 6 had cancer, diabetes, high blood pressure, heart disease, or kidney disease? If "YES", identify family member, disorder, age of onset. If there is a history of cancer, indicate kind(s) of cancer.	☐	☐
8. At any time during the past five years have you been hospitalized or have you consulted, been examined or treated by any other physician, psychiatrist, or medical practitioner not disclosed in response to Questions 2 through 4? If "YES", list all occurrences and provide name(s)/address(es), dates, and reasons.	☐	☐
9. Have you:		
a. Been advised, in the last two years, to have any diagnostic test, surgery, or hospitalization which has not been completed?	☐	☐
b. Have you ever been treated for dizziness, headaches, tremors, muscle weakness, persistent hoarseness or cough, or coughing up blood?	☐	☐
c. Have you been diagnosed or treated by a member of the medical profession as having AIDS, ARC, or the HIV infection?	☐	☐
d. Ever received any sickness or disability pension, benefits, or compensation?	☐	☐
e. Ever attempted suicide or sought counseling for suicide prevention or for thoughts about suicide?	☐	☐
f. Any mental or physical disorder not listed in response to Questions 2 through 9?	☐	☐
10. Are you currently taking or have you been advised to take any medication? If "YES", list name of medication, reason, and doctor's name and address.	☐	☐
11. What is your height? ____________ Weight? ____________ Have you lost weight in the past year? If "YES", provide amount of weight loss and reason in Number 13.	☐	☐

12. Who is your personal physician? *If none, state none.*

Name ______________________________

Street ______________________________

City ______________________________ State ____________ Zip ____________

Phone No. (   ) ______________________________ Date last seen? ____________

Why? ______________________________ Results? ______________________________

What tests were made? ______________________________ Were the results normal? *(If no, give details below.)* ☐ Yes ☐ No

13. Details of Items 7 through 12. Give complete details for all "Yes" answers. Identify question number and include diagnoses, dates, durations, treatments and medications prescribed, and names/addresses of all physicians, psychiatrists, psychologists, and hospitals. Use #5, if additional space needed.

Question No.	

All statements and answers to the foregoing questions in this Part Two application are, to the best of my knowledge and belief, true, complete, and correctly stated. I agree that a copy of this Part II shall be attached to and form part of any policy issued based on my application.

Dated at ______________________________ (City) ______________________________ (State) On ______________ (Month/Day/Year)

____
Signature of **Proposed Insured**

____
Signature of Witness ☐ Examiner ☐ Agent