



Medical Application Part II

GE Financial
Employer Services Group

GE Group Life Assurance Company
Attn.: Group Medical Underwriting 1E322
100 Bright Meadow Boulevard, PO Box 1555
Enfield, CT 06033-1555

Examination to be made in private. Please read all questions to applicant. Answers to be recorded by the Medical Examiner in his/her own handwriting.

Name of Proposed Insured (Last, First, M.I.)		Sex	Date of Birth	Occupation		Account Number		
1. Personal Physician: (if none, so state) Name:			g. Family Record	Age	Health	Age at Death	Cause of Death	
Address:			Father					
			Mother					
Date last seen:			Brothers and Sisters No. Living _____ No. Dead _____					
Reason and Outcome:			Yes No Please Check (✓) Appropriate Column					
<input type="checkbox"/>	<input type="checkbox"/>	2. To your knowledge, have any of your parents, brothers, or sisters had tuberculosis, nervous or mental disorder, or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	j. Impairment of hearing or eyesight?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	3. a. Have you ever had or been treated for alcoholism or any drug habit?	<input type="checkbox"/>	<input type="checkbox"/>	k. Paralysis, deformity, or any injury or disorder of the muscles, bones, joints, spine, or back?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	b. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or other drugs except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	l. Hernia, hemorrhoids, or varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever applied for or received sickness or accident benefits or a disability pension from any source?	<input type="checkbox"/>	<input type="checkbox"/>	m. Other than above, any physical or mental disorder, operation, or injury within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you sought treatment or consulted a physician or other practitioner for any reason in the last 5 years, including routine examinations or check-ups? (Give full details)	<input type="checkbox"/>	<input type="checkbox"/>	n. AIDS-related complex (ARC) or acquired immune deficiency syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	6. a. Have you ever been a patient in any hospital, sanatorium, or similar institution?	<input type="checkbox"/>	<input type="checkbox"/>	9. a. Have you ever had	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	b. Have you ever had, or been advised to have any surgical operations, X-rays, electrocardiograms, blood studies, or other tests?	<input type="checkbox"/>	<input type="checkbox"/>	(1.) Abnormal menstruation, abnormal pregnancies or complications, miscarriage or Caesarean delivery?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	c. Has a physician ever advised you to diet?	<input type="checkbox"/>	<input type="checkbox"/>	(2.) Disease of the breasts, ovaries, or uterus?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	d. Is there any kind of medicine which you take regularly or at frequent intervals?	<input type="checkbox"/>	<input type="checkbox"/>	b. Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	7. To the best of your knowledge have you ever had or been told by a physician or other practitioner that you had:	<input type="checkbox"/>	<input type="checkbox"/>	(If "yes", give expected date of confinement.)	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	a. High blood pressure? (If "yes", give full details of any treatment given.)	10. a. Have you ever been declined, postponed, rated, or riders for insurance?					<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	b. Pain, pressure, or discomfort in the chest, palpitation, swelling of the ankles, or undue shortness of breath?	b. Are you negotiating for other insurance?					<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	c. Heart disease, heart murmur, angina pectoris, or coronary disease?	(If "yes" name companies and amounts.)					<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	d. Rheumatic fever, chorea, rheumatism, or arthritis?	Details of all questions answered "yes". Include Dates, Names, and Addresses of all doctors consulted, Duration, Treatment and Results.					
<input type="checkbox"/>	<input type="checkbox"/>	e. Pneumonia, pleurisy, asthma, tuberculosis, chronic cough, or any other disease of the lungs?	Failure to answer all questions and supply all relevant details may result in underwriting delays.					
<input type="checkbox"/>	<input type="checkbox"/>	f. Epilepsy, fainting spells, concussion, skull fracture, severe headaches, dizziness, mental disorder or nervous breakdown?						
<input type="checkbox"/>	<input type="checkbox"/>	g. Indigestion, stomach or duodenal ulcer, colitis, or other disease of the intestines or rectum, gall bladder disorder, jaundice, hepatitis, or liver disorder?						
<input type="checkbox"/>	<input type="checkbox"/>	h. Kidney disease, nephritis, kidney stone, bladder or prostate trouble, or albumin, sugar, pus, or blood in the urine?						
<input type="checkbox"/>	<input type="checkbox"/>	i. Diabetes, syphilis or other sexually transmitted disease, gout, thyroid disease, enlarged glands, tumor, polyp, cancer or skin disease?						

The foregoing statements are full, complete and true to the best of my knowledge and belief.

Dated _____

Date _____

Witness _____

Examiner _____

Proposed Insured Sign Post Name _____

Do Not Detach - Please Complete Authorization to Release Information

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to GE Group Life Assurance Company ("GELAC") and its legal representatives: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group policyholder or certificate holder.

I understand that the information released to GELAC will be used to determine my eligibility for the insurance requested. GELAC may disclose such information for that purpose to the employer or union connected with the group insurance coverage involved herein, the group policyholder or certificate holder, or their representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GELAC. This information may also be disclosed as otherwise specifically permitted or required by law. This authorization is valid for up to 24 months from the date it was executed. A photocopy of this authorization shall be as valid as the original.

This authorization extends to and includes HIV-related information, AIDS or AIDS-related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. This authorization or photocopies of it will be valid for two and one half years following the date signed, unless otherwise required by law. The information released to GELAC will not be given, sold or transferred to any other person or entity not mentioned above.

I understand that I am entitled to a photocopy of this authorization upon request.

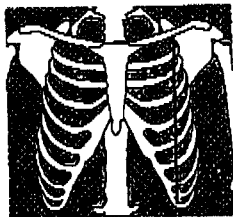
Date _____

Proposed Insured _____

Medical Examiner's Report

Where indicated, give full details under questions 3 or in a separate letter to the Medical Director

Yes	No	Please Check (✓) Appropriate Column	Yes	No	Please Check (✓) Appropriate Column
<input type="checkbox"/>	<input type="checkbox"/>	1. In general appearance as to health and habits good? (If "No", give details under number 8)	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you find any evidence of past or present disease of:
<input type="checkbox"/>	<input type="checkbox"/>	2. a. Height in shoes _____ ft. _____ in. Weight (Clothed) _____ lbs. Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Brain or nervous system? (Test patellar and pupillary reflexes and observe gait.)
<input type="checkbox"/>	<input type="checkbox"/>	b. Any change in weight in past year? Gain _____ lbs. Loss _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	b. Lungs or respiratory organs?
<input type="checkbox"/>	<input type="checkbox"/>	c. Reason for change? _____	<input type="checkbox"/>	<input type="checkbox"/>	c. Abdomen? (Describe scars, tenderness or masses. If a hernia is present, give size and reducibility.)
<input type="checkbox"/>	<input type="checkbox"/>	d. Present weight maintained how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	d. Genitourinary system? (Examine prostate if indicated by history.)
<input type="checkbox"/>	<input type="checkbox"/>	e. Chest: inspiration _____ ins. expiration _____ ins. abdomen _____ ins.	<input type="checkbox"/>	<input type="checkbox"/>	e. Eyes, ears, nose or throat?
<input type="checkbox"/>	<input type="checkbox"/>	3. a. Any varicosities, edema, amputation or deformity?	<input type="checkbox"/>	<input type="checkbox"/>	f. Bones, lymph glands, thyroid or skin?
<input type="checkbox"/>	<input type="checkbox"/>	b. Artificial limb, brace or crutch used?	<input type="checkbox"/>	<input type="checkbox"/>	g. Any part of the body?
<input type="checkbox"/>	<input type="checkbox"/>	4. Cardiovascular Examination	<input type="checkbox"/>	<input type="checkbox"/>	7. Urinalysis (Dipstick required for every exam)
<input type="checkbox"/>	<input type="checkbox"/>	a. Blood pressure (sitting) Systolic _____ Diastolic _____ If pressure is above 140x systolic or 90 diastolic or if there is a history of hypertension, take at least three additional readings at intervals and record under 8 "Details".	<input type="checkbox"/>	<input type="checkbox"/>	Albumin: _____
<input type="checkbox"/>	<input type="checkbox"/>	b. Pulse Rate	<input type="checkbox"/>	<input type="checkbox"/>	Sugar: _____
<input type="checkbox"/>	<input type="checkbox"/>	c. Irregularities	<input type="checkbox"/>	<input type="checkbox"/>	Specific Gravity _____
			<input type="checkbox"/>	<input type="checkbox"/>	Send Home Office Specimen only if
			<input type="checkbox"/>	<input type="checkbox"/>	1. Specimen is abnormal or
			<input type="checkbox"/>	<input type="checkbox"/>	2. History or finding of diabetes, hypertension, or S.U. disease.
			<input type="checkbox"/>	<input type="checkbox"/>	Is specimen being sent?
			8. Details and Additional Remarks:		
Questions 5 and 6 to be answered if Examiner is M.D.					
<input type="checkbox"/>	<input type="checkbox"/>	5. a. Any dyspnea, pain or discomfort after exercise?			
<input type="checkbox"/>	<input type="checkbox"/>	b. Any sclerosis of peripheral vessels, clubbing or cyanosis?			
<input type="checkbox"/>	<input type="checkbox"/>	c. Is the heart enlarged? (locate apex by (x) on diagram.)			
<input type="checkbox"/>	<input type="checkbox"/>	d. Is there a murmur? (Examine heart in erect and recumbent positions.)			
			Timing: <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic		
			Intensity: <input type="checkbox"/> Faint <input type="checkbox"/> Moderate <input type="checkbox"/> Loud		
			Please comment on the presence or absence of thrills or any undue accentuation of heart sounds, and on the effect of exercise, change of position, or phase of respiration.		
			On Diagram, Locate: Apex by X Area of murmur by ○		
			Point of maximum intensity by ● Transmission by →		
			e. Based on the history and findings, what is your impression of the cardiac status?		
			9. Has this applicant used any type of tobacco products in the past 36 months?		
			10. Please state fee if applicable \$ _____		



To the Medical Examiner: Any erasures or alterations in this report should be initialed by you. If you prefer to do so, you may send this report or any information which you prefer not to embody in this report to the Medical Director of the Company, 100 Bright Meadow Blvd, P.O. Box 1955, Enfield, CT 06033-1955. (Use separate sheet if necessary.)

Dated at _____ Date _____

Examination made at Office or Residence of Examiner or Proposed Insured at _____ A.M. or _____ P.M.

At request of Group Medical Underwriting - Enfield

Signature _____ Tax I.D. # _____

Address _____