

**PART II** Check the appropriate company.

Case/Policy # \_\_\_\_\_ **1**

**Paramedical/  
Medical Exam**

- Metropolitan Life Insurance Company
- MetLife Investors Insurance Company
- New England Life Insurance Company

- Metropolitan Tower Life Insurance Company
- MetLife Investors USA Insurance Company
- General American Life Insurance Company

The Company indicated above is referred to as "the Company."

The questions below are directed to the person to be examined. Record ONLY this person's answers in the spaces below.

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Tobacco Use -- Indicate date last smoked/used:  
Cigarette \_\_\_\_\_  Never Smokeless Tobacco \_\_\_\_\_  Never Cigar/Pipe \_\_\_\_\_  Never  
Nicotine Substitute (i.e., Patch, Gum, etc.) \_\_\_\_\_  Never Amount/Frequency \_\_\_\_\_ How Long \_\_\_\_\_ yrs.

3. Please provide name of doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health. If **None**, check .

Physician Name \_\_\_\_\_ Name of Practice/Clinic \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Date Last Consulted \_\_\_\_\_

Reason \_\_\_\_\_

Findings, treatment given, medication prescribed. If **None**, check . \_\_\_\_\_

Reasons, findings, earlier consultations past 5 years \_\_\_\_\_

4. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Change in weight in past 12 months?  Yes  No  
If **Yes**, Pounds lost \_\_\_\_\_ Pounds gained \_\_\_\_\_ Reason \_\_\_\_\_

5. Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:

- a) High blood pressure; chest pain; heart attack; irregular heartbeat; peripheral vascular disease; or any other disease or disorder of the heart or circulatory system (blood vessels)?  Yes  No
- b) Asthma; bronchitis; pneumonia; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?  Yes  No
- c) Seizures; stroke; paralysis; Alzheimer's disease or other form of dementia; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder of the brain or nervous system?  Yes  No
- d) Ulcers; colitis; hepatitis; cirrhosis; pancreatitis; or any other disease or disorder of: the liver; pancreas; gallbladder; esophagus; stomach; spleen; or intestines?  Yes  No
- e) Any disease or disorder of: the breasts; reproductive organs; or the genitourinary system, including but not limited to: the kidney; bladder; or prostate; or blood, protein or pus in the urine?  Yes  No
- f) Diabetes; thyroid disorder; elevated cholesterol or other lipid disorder; or any other endocrine disease or disorder?  Yes  No
- g) Arthritis; gout; osteoporosis; or other disease or disorder of the: muscles; bones; spine (discs, back, neck); or joints?  Yes  No
- h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin?  Yes  No
- i) Anemia; leukemia; or any other disease or disorder of the blood or lymph glands?  Yes  No
- j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?  Yes  No
- k) Any disease or disorder of the eyes, ears, nose, or throat?  Yes  No

Details: List question number. Give: dates; duration/ description of condition; diagnosis; treatment; physician, practitioner or health facility names and addresses.



Details (Continued):

- 6. Are you now, or within the past year, taking medication or receiving treatment? (Including over the counter medications, vitamins, herbal supplements, alternative therapies, etc.)  Yes  No
- 7. Do you have any doctor's visits, medical tests, medical care, or surgery scheduled for the next six months?  Yes  No
- 8. Other than the above, during the past five years have you had any:
  - a) Checkup; consultations; electrocardiogram; chest x-ray; or other medical test?  Yes  No
  - b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?  Yes  No
- 9. Have you:
  - a) ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
  - b) ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) virus or for antibodies to the AIDS (HIV) virus?  Yes  No
- 10. a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?  Yes  No
  - b) Have you ever received treatment from a physician, practitioner, health facility or counselor regarding the use of alcohol, or the use of drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?  Yes  No

11. Do you exercise?  Yes  No Type \_\_\_\_\_ How often? \_\_\_\_\_

12. Are you now pregnant?  Yes  No If Yes, estimated date of delivery? \_\_\_\_\_

13. Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer? (If Yes, indicate below.)  Yes  No


Relationship to Proposed Insured:	Age(s) if living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

- 14. a) Do you currently use any assisted devices such as: a walker; wheelchair; long leg braces; cane; or crutches?  Yes  No
- b) Do you need any assistance or supervision with any or all of the following activities: eating; bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence or taking medication?  Yes  No

If Yes, provide details above.

I have read the answers to questions 2-14 before signing. They correctly reflect the answers given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

 Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

 Witness to Signature \_\_\_\_\_ City and State \_\_\_\_\_



**Report of Paramedical/Medical Examiner**

**Section 1 Complete for All Exams**

1. Name of person examined \_\_\_\_\_ Date/Time of exam \_\_\_\_\_
2. Sex: **M**  **F**  If female, was Proposed Insured menstruating on date of this examination? **Yes**  **No**
3. Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight (clothed) \_\_\_\_\_ lbs.  
Chest (full inspiration) Males \_\_\_\_\_ in. Chest (forced expiration) Males \_\_\_\_\_ in. Abdomen (at umbilicus) Males \_\_\_\_\_ in.  
Did you measure? **Yes**  **No**  Did you weigh? **Yes**  **No**
4. Blood Pressure: Sitting Systolic/Diastolic – 5th phase \_\_\_\_\_ / \_\_\_\_\_  
If systolic over 140 or diastolic over 90, repeat later in exam \_\_\_\_\_ / \_\_\_\_\_
5. Pulse At Rest: Rate (per min.) \_\_\_\_\_ Irregularities (per min.) \_\_\_\_\_
6. Is appearance unhealthy or older than stated age? **Yes**  **No**
7. Urinalysis: Protein: **Positive**  **Negative**  Sugar: **Positive**  **Negative**   
Is blood also being sent to lab? **Yes**  **No**  ECG done? **Yes**  **No**

Urine samples must be sent to lab for analysis  
**Place Kit Sticker Here**

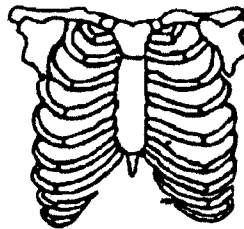
**Section 2 Complete for Physician Exam Only**

Details for answers to questions 8-12:

8. Heart: Is there any: a) Enlargement?  **Yes**  **No** c) Dyspnea?  **Yes**  **No**  
b) Murmur(s)? (If **Yes**, complete below)  **Yes**  **No** d) Edema?  **Yes**  **No**

	Murmur 1	Murmur 2
Location (Apical, Aortic, Pulmonic, Parasternal)		
Timing (Systolic, Presystolic, Diastolic)		
Quality (Coarse, Blowing, Rumbling, Musical)		
Loudness (Grade 1-6)		
Constant (Yes or No)		
Transmitted (Yes or No)		
After Exercise (Increased, Absent, Unchanged, Decreased)		

- Indicate:  
Apex by: **X**  
Murmur area by:   
Point of greatest intensity by: **O**  
Transmission by: **→**



9. Is there on examination any abnormality of the following?
  - a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)  **Yes**  **No**
  - b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?  **Yes**  **No**
  - c) Nervous system (include reflexes, gait, and paralysis)?  **Yes**  **No**
  - d) Respiratory system?  **Yes**  **No**
  - e) Abdomen (describe scars, liver enlargement)?  **Yes**  **No**
  - f) Genitourinary system?  **Yes**  **No**
  - g) Endocrine system (include thyroid)?  **Yes**  **No**
  - h) Musculoskeletal system (include spine, joints, amputations, and deformities)?  **Yes**  **No**

10. Are there any hernias?  **Yes**  **No**

11. Are you aware of additional medical history?  **Yes**  **No**

12. Are you the personal physician of the applicant?  **Yes**  **No**

13. Please provide your overall clinical impression of Proposed Insured:



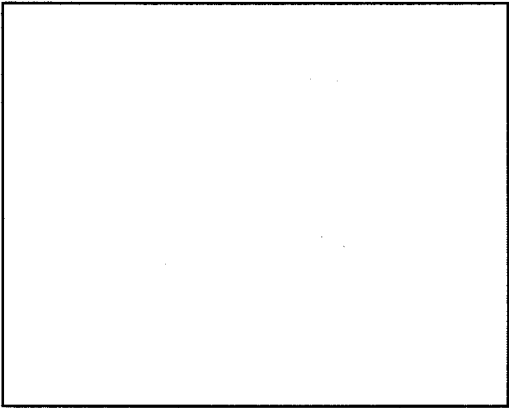
**Section 3 Complete for Proposed Insureds Age 70 and Over**

1. Ask the Proposed Insured if he/she:
  - a) Has a history of falls within the last year.  Yes  No  
 If **Yes**, provide details of all falls (including how many, dates, reason, and treatment).  
 \_\_\_\_\_
  - b) Lives with another person.  Yes  No  
 If **Yes**, relationship to Proposed Insured? \_\_\_\_\_  
 How often do you visit with family/friends? \_\_\_\_\_  
 Lives in an assisted living facility or other facility with services on site?  Yes  No
  - c) Drives.  Yes  No  
 If **Yes**, does the Proposed Insured have a handicap license plate or sticker?  Yes  No  
 If **No**, when and why did the Proposed Insured stop? \_\_\_\_\_
  - d) Works, volunteers, travels, and/or has hobbies.  Yes  No  
 If **Yes**, provide details (including type of activity and how often). \_\_\_\_\_  
 \_\_\_\_\_
  - e) Needs assistance with any or all of the following activities: (Check only those that apply:)  Yes  No

<input type="checkbox"/> Cooking/M meal Preparation	<input type="checkbox"/> House Cleaning	<input type="checkbox"/> Laundry
<input type="checkbox"/> Shopping	<input type="checkbox"/> Handling Finances	<input type="checkbox"/> Using the Telephone

 If **Yes**, provide details. \_\_\_\_\_  
 \_\_\_\_\_

2. Point to three objects and ask the Proposed Insured to tell you what they are and indicate that you are going to ask them to recall these later. Record the three objects exactly as the Proposed Insured states them.  
 \_\_\_\_\_
3. Ask the Proposed Insured to stand up, walk at least 10 feet, turn around, walk back, and sit down in the same place. Observe and record the performance (Comment on speed and steadiness; note any hesitancy, limping, unsteadiness, etc.).  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Please have the Proposed Insured draw a clock reading 11:10. If more space is required for the drawing, please attach a separate page.
5. Now ask the Proposed Insured to remember the three objects from earlier. Ask him/her to restate them. Please record his/her exact response here.  
 \_\_\_\_\_



**EXAMINER'S ASSESSMENT**

1. If exam was conducted in the home, describe the Proposed Insured's living situation and possible safety issues: home – with stairs; home – one level; clean appearance; loose carpeting; untidy/disrepair; cluttered hallways/sidewalks; etc.  
 \_\_\_\_\_
2. Describe the Proposed Insured's appearance: average build; well groomed; appears healthy; slender build; poorly groomed; appears fragile; obese; poor dentition; etc.  
 \_\_\_\_\_

**Section 4 Complete for All Exams**

Place of exam:  Examiner's Office  Proposed Insured's Residence  Proposed Insured's Business  Other \_\_\_\_\_

City/State \_\_\_\_\_

Agent/Broker \_\_\_\_\_ Branch/District# or Agency Name \_\_\_\_\_

Signature of Paramedical/Physician Examiner \_\_\_\_\_

Printed Name of Examiner \_\_\_\_\_ TIN of Examiner \_\_\_\_\_

Address of Examiner \_\_\_\_\_ Vendor Name \_\_\_\_\_

Was the exam conducted with a translator?  Yes  No

If **Yes**, what is the translator's relationship to the Proposed Insured? \_\_\_\_\_



Details (Continued):

- 6. Are you now, or within the past year, taking medication or receiving treatment? (Including over the counter medications, vitamins, herbal supplements, alternative therapies, etc.)  Yes  No
- 7. Do you have any doctor's visits, medical tests, medical care, or surgery scheduled for the next six months?  Yes  No
- 8. Other than the above, during the past five years have you had any:
  - a) Checkup; consultations; electrocardiogram; chest x-ray; or other medical test?  Yes  No
  - b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?  Yes  No
- 9. Have you:
  - a) ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
  - b) ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) virus or for antibodies to the AIDS (HIV) virus?  Yes  No
- 10. a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?  Yes  No
  - b) Have you ever received treatment from a physician, practitioner, health facility or counselor regarding the use of alcohol, or the use of drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?  Yes  No

11. Do you exercise?  Yes  No Type \_\_\_\_\_ How often? \_\_\_\_\_

12. Are you now pregnant?  Yes  No If Yes, estimated date of delivery? \_\_\_\_\_

13. Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer? (If Yes, indicate below.)  Yes  No

Relationship to Proposed Insured:	Age(s) if living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

- 14. a) Do you currently use any assisted devices such as: a walker; wheelchair; long leg braces; cane; or crutches?  Yes  No
- b) Do you need any assistance or supervision with any or all of the following activities: eating; bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence or taking medication?  Yes  No

If Yes, provide details above.

I have read the answers to questions 2-14 before signing. They correctly reflect the answers given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

 Signature of Proposed Insured \_\_\_\_\_ (PARTY OR GUARDIAN IN LIEU OF) Date \_\_\_\_\_ (MONTH/DAY/YEAR)

 Witness to Signature \_\_\_\_\_ City and State \_\_\_\_\_



Metropolitan Life Insurance Company  
One Madison Avenue  
New York, NY 10010-3690

Security First Life Insurance Company  
1300 Delaware Trust Bldg. P.O. Box 23130  
Wilmington, DE 19899

The Company checked off above is referred to as "the insurer."

**CALIFORNIA NOTICE AND CONSENT FORM FOR BLOOD OR OTHER BODILY  
FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the insurer named above ("the insurer") has requested that you provide a sample of your blood or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved in the underwriting and claims review process. If the HIV test is positive the results will be reported to the Medical Information Bureau (MIB, Inc.) in a generic code which signifies only non-specific blood or other bodily fluid test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer or your designated physician will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this HIV Notice and Consent form. I have also received a list of AIDS counseling centers from the insurer. I voluntarily consent to the withdrawal of blood or other bodily fluids from me, the testing of that blood or other bodily fluids, and the disclosure of the test results as described above.

In the event of an HIV test result that is other than normal, I authorize the insurer to send the test results to the following health care professional for post-test counseling.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
City State ZIP Code

**I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST AND RECEIVE A COPY OF THIS AUTHORIZATION. A PHOTOCOPY OF THIS FORM WILL BE AS VALID AS THE ORIGINAL.**

\_\_\_\_\_  
Proposed Insured (Print)

\_\_\_\_\_  
Date of Birth

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Agency / District Name/Number

18000073094 (02/1998)

Company Copy