

PRINT CLEARLY

Applicant: _____ Application # _____

Agent: _____ Agent # _____

Agent Phone # _____

Coverage(s) applied for: Medical Life Disability Long Term Care

Please complete only those items that are checked and return the completed form directly to the Underwriting Department of Time Insurance Company.

Height _____ feet _____ inches Weight _____ pounds

Was the applicant actually weighed and measured? Yes No

Blood Pressure:

SYSTOLIC	1. _____	2. _____	3. _____
DIASTOLIC	_____	_____	_____

Did you take diastolic at:
Disappearance of all sound? Phase V
Change of sound? Phase IV

(Note: Only one reading is required unless the systolic reading exceeds 140 or the diastolic reading exceeds 90)

Has the applicant ever been treated for high blood pressure? YES NO

Has the applicant used any form of tobacco products during the past year? YES NO

Provide full details to any "yes" answers on the back of this form.

Please complete the following test(s) and forward the specimen(s) to:
Osborn Laboratories
P.O. Box 2920
Shawnee Mission, Kansas 66201-9890

Dried Blood Spot (DBS) and urinalysis

Venipuncture blood draw and urinalysis

Signature of Proposed Insured _____ Date _____ Time _____

Proposed Insured Social Security Number: _____

Examiner _____ Address: _____

Examiner Phone Number: _____

City: _____ State: _____ Zip Code: _____

Individual Practitioners S.S. No. _____	_____	_____	All Others—Employer I.D. No. _____	_____	_____
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Federal Law (I.R.C. Sec. 6100) Requires This Number To Be Furnished