

MEDICAL EXAMINER'S REPORT

PART III

1. a.	Measured Height	Scale Weight	Chest (Full	Chest (Forced	Abdomen, at
	(In shoes)	(Clothed)	Inspiration)	Expiration)	Umbilicus
	ft. in.	lbs.	in.	in.	in.
b.	Any change of weight in past year? _____ Cause _____				
c.	Is appearance unhealthy? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Details of "Yes" answers. (Identify item.)

2. **Blood Pressure**
(Record All readings)

	At Rest	After Exercise	3 Minutes Later
Systolic			
Diastolic 5th phase			

3. **Pulse:**

Rate			
Irregularities per min.			

4. Heart: Is there any:
 Enlargement Yes No; Dyspnea Yes No; Edema Yes No; History of rheumatic fever Yes No
 Murmur(s) Yes No (If yes, give details below.)

Murmur 1 Murmur 2

Specify Location: _____
 [Mitral, aortic, pulmonary, elsewhere (specify)]

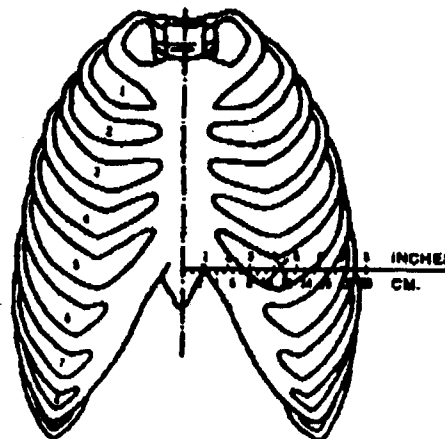
Constant	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>

Timing:		
Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>

Grade:		
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>

After exercise:		
Increased	<input type="checkbox"/>	<input type="checkbox"/>
Absent	<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 ⊙
 Point of greatest intensity by ●
 Transmission by ◀



Comments and your diagnosis?
 Does the murmur impress you as organic as functional

5. Is there on examination any abnormality of the following:
 (Circle applicable items and give details.)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? <small>(If vision or hearing markedly impaired, indicate degree and correction.)</small>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genito-urinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

6. Are there any:
 (a) Hernias? Yes No
 (b) Hemorrhoids? Yes No

7. Are you aware of additional medical history? Yes No

(A confidential report may be sent to the Medical Director)

(over)

8. Urinalysis:	Albumin:	Sugar:
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Are you forwarding a specimen to the Home Office reference laboratory? (Check one)

No Urine Blood (If so, answer (a))

(a) Is the subject fasting? Yes No (If not, answer (b))

(b) Time of last food intake: _____ A.M. or P.M.
(Include soft drinks, coffee, tea, candy or gum)

Specify Liquid _____

Specify Snack _____

Specify Regular Meal _____

(c) Time Blood Drawn _____ A.M. or P.M.

PLEASE FORWARD SPECIMENS TO HOME OFFICE REFERENCE LABORATORY IF ANY CARDIOVASCULAR/RENAL FINDINGS
Use The Space Below For Additional Comments If Necessary

I Certify that I have carefully examined _____ of _____
(City and Street Address)

in private, at $\left. \begin{array}{l} \text{my office} \\ \text{his place of business} \\ \text{his home} \end{array} \right\}$ this _____ day of _____, 19____ at _____ A.M. — P.M.

Signature of Examiner _____ Address _____

Review report carefully for completeness of all sections. Then mail directly and without exception to the Medical Director at the Executive Office of the Company.
THE COMPANY APPRECIATES CONFIDENTIAL INFORMATION ALWAYS

\$
FEE
Fed. I.D.

GOLDEN RULE INSURANCE COMPANY
712 Eleventh Street
Lawrenceville, Illinois 62439
618-943-8000

**NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one -- or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature

Agent's Signature

Date

Date

Applicant's Name and Address (Printed)

Agent's Name and Address (Printed)

Give one signed copy of this form to the applicant. Send the second copy of this form to Golden Rule.

Golden Rule

Golden Rule Insurance Company

Home Office

712 Eleventh Street

Lawrenceville, Illinois 62439

Notice to Elders Regarding Sale of Life Insurance or Annuities in the State of California

("Elder" is defined by California law as any person residing in the state of California who is sixty-five (65) years of age or older.)

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

Signature of Elder or Elder's Representative

Date

Jan 4 2005 02:46:37 pm

33739-0801

Golden Rule

Golden Rule Insurance Company
Home Office
Golden Rule Building
12 Eleventh Street
Lawrenceville, Illinois 62439

Notice and Consent for Bodily Fluid Testing Which Will Include AIDS Virus (HIV) Antibody/Antigen Testing Application for Life Insurance

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

The consent you give by signing this form authorizes the Insurer to collect blood and/or other body fluids and order laboratory tests only in regard to your present application for life insurance. The cost of any testing will be borne by the Insurer.

Unless precluded by law, 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 that we perform 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 or kidney disorders, diabetes, and immune disorders.

If we test our blood or urine we will use an ELISA or a Western Blot Assay, or both. An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same specimen. A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

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 solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. The Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. 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 a 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 that 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 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 will ask you for the name of a physician or other health care provider 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 that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antigen test/screening results or other significant test 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 understand this Notice and Consent For Bodily Fluid Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the collection of my bodily fluid(s), the testing of my bodily fluid(s), and the disclosure of the test results as described above.

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. This consent shall be valid for a period of 30 months from the date noted below.

Proposed Insured

Date of Birth

Name and address of designated Physician:

Signature of Proposed Insured or Parent/Guardian

Date

State of Residence

(This list must be left with the applicant.)

COUNSELING RESOURCES LIST

Public health authorities urge that everyone becomes educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Golden Rule Insurance Company. Therefore, Golden Rule makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Golden Rule makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM-Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM-Fresno
(209) 264-2436

AIDS PROJECTS-EASY BAY-Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION- Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION-
San Francisco
(415) 846-5855

AIDS PROJECT-LOS ANGELES-West Hollywood
(213) 876-8951

INLAND AIDS PROJECT-Riverside/San Bernardino
Counties
(714) 784-2437

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION
HOTLINE
(707) 579-AIDS

AIDS HOTLINE-SOUTHERN CALIFORNIA
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF SOUTHERN
CALIFORNIA-Social Services-Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services-Office of AIDS-Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE
COUNTY-Costa Mesa
(714) 646-0411

SAN DIEGO AIDS PROJECT
(619) 543-0300-City of San Diego
(619) 945-6000-City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252