

APPLICATION PART 2 TO THE GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY

Proposed Insured	Birth Date:						
<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">First name</td> <td style="width:33%; border: none;">Middle initial</td> <td style="width:33%; border: none;">Last name</td> </tr> </table>	First name	Middle initial	Last name	<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">Month</td> <td style="width:33%; border: none;">Day</td> <td style="width:33%; border: none;">Year</td> </tr> </table>	Month	Day	Year
First name	Middle initial	Last name					
Month	Day	Year					

1. a. Name and address of your personal physician? _____
(If none, so state)
- b. Date and reason last consulted? _____
- c. What treatment was given or medication prescribed? _____

2. Have you ever been treated for or ever had any known indication of:
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Disorder of eyes, ears, nose, or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes; thyroid or other endocrine disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor, or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco, or any habit-forming drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Any mental or physical disorder not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |
3. Are you now under observation or taking treatment?
4. Have you had any change in weight in the past year?
5. *Other than above*, have you within the past 5 years:
- | | | |
|---|--------------------------|--------------------------|
| a. Had a checkup, consultation, illness, injury, surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic, sanatorium, or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had electrocardiogram, X-ray, other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide.

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

9. Females only: Yes No
- a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?.....
- b. Are you now pregnant?

I hereby declare that all of the statements and answers to the above questions are complete and true and include full particulars of each and every part of questions 2 through 8 to which the answer is "Yes". I agree that the foregoing together with this declaration shall form a part, designated as Part 2, of the application for insurance.

Witness _____ M.D. _____

Signature of Person Examined _____

Date _____ 19 _____

MEDICAL EXAMINER'S REPORT

a. Height (In Shoes)	Weight (Clothed)		Males Only:			Details of "Yes" answers. (Identify item.)
			Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	
ft. in.	lbs.	in.	in.	in.		

b. Did you weigh? Yes No **Did you measure?** Yes No

c. Is appearance unhealthy or older than stated age? Yes No

1. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	4th phase		
	5th phase		

2. Pulse:

Rate	At Rest	After Exercise	3 Minutes Later
Irregularities per min.			

13. Heart: Is there any:

Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No

(describe below - if more than one, describe separately)

Location										
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Indicate:							
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by							X
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by							⊙
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by							⊖
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by							◆
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	For comments and your impression?							
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>								
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"/>								

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

(a) Eyes, ears, nose, mouth, pharynx?	Yes	No
(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) Genitourinary 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"/>

15. (a) Are there any hernias? Yes No **(b) Any hemorrhoids?** Yes No

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

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

Analysis: Specific Gravity	Albumin	Sugar	Send Specimen To Home Office If:
			(a) You found albumin or sugar in the urine; (b) there is a history of cardiovascular or urinary tract abnormality; (c) blood pressure is more than 140 systolic or more than 90 diastolic.
specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No			

I certify that on the date shown I examined the person described herein whose answers to the questions on the reverse were recorded as given me, and whose signature was written in my presence.

te _____ 19____ M.D. Examining Physician

without delay. This should be done regardless of the condition of the person examined, the inability to complete the report in all details, or the request of anyone to the contrary.

PRINT

EXAMINING PHYSICIAN'S VOUCHERS (Do Not Detach)

It is important that this voucher be fully and properly completed

Name of Person Examined			Date of Examination
Examining Physician			Amount of Insurance \$
Address of Examining Physician (No. & Street)	(City & State)	Zip Code	Name of Agent Requesting Examination

21 R/97

PRENOTICE

THIS PRENOTICE FORM MUST BE DETACHED AND GIVEN TO THE APPLICANT OR PROPOSED INSURED BEFORE THIS APPLICATION IS COMPLETED

Information regarding your insurability will be treated as confidential. The Golden State Mutual Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 106, Essex Station, Boston, Mass. 02112. Telephone number (617) 428-3660.

The Golden State Mutual Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.