

**IN CONTINUATION OF AND FORMING A PART OF APPLICATION FOR INSURANCE TO
GREAT AMERICAN[®] LIFE INSURANCE COMPANY, LIFE PRODUCTS
P.O. BOX 5416, CINCINNATI, OHIO 45201-5416**

Proposed Insured _____ **Birth Date:** _____
 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? _____

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF,

2. Has anyone proposed for coverage ever been treated for or had:
- a. Impairment of the eyes or ears? Yes No
 - b. Dizziness, fainting, convulsions, headache, paralysis or stroke within the past ten years? Yes No
 - c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema, or chronic respiratory disorder within the past ten years? Yes No
 - d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? Yes No
 - e. Jaundice, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver or gallbladder? Yes No
 - f. Sugar, proteinuria, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? Yes No
 - g. Diabetes, thyroid or other endocrine disorders? Yes No
 - h. Disorder of breasts or pelvic organ? Yes No
 - i. Neuritis, arthritis, or disorder of the muscles or bones, including the spine, back or joints? Yes No
 - j. Disorder of skin, lymph glands, cyst, tumor, or cancer? Yes No
 - k. Anemia or other disorder of the blood? Yes No
 - l. Alcoholism or addiction to use of habit-forming drugs? Yes No
 - m. Any mental or physical disorder not listed above? Yes No

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.)

3. Has anyone proposed for coverage:
- a. Had a physical checkup, consultation, or surgery within the last five years? Yes No
 - b. Been a patient in a hospital, clinic, or other medical facility within the last five years? Yes No
 - c. Had an electrocardiogram, X-ray, or other diagnostic test within the last five years? Yes No
 - d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed? Yes No

- e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes No
- f. Ever had any disorder of menstruation, pregnancy or of the reproductive organs or breasts? Yes No
- 4. Are you now pregnant? If yes, expected due date? Yes No
- 5. Is anyone proposed for coverage now under medical observation or treatment? Yes No

PROPOSED INSURED'S FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers and Sisters			

To the best of your knowledge and belief, has any member of your family had alcoholism, cancer, diabetes, high blood pressure, or heart disease?
 Yes No
 (If "Yes," give details)

I or we, the undersigned, declare that the answers to the foregoing questions relate to the proposed insured, are complete and true as written to the best of my/our knowledge and belief, are correctly recorded, are made for the purpose of obtaining the insurance and any supplemental benefit applied for and shall form a part of any contract issued by the Company on this application (Part I and Part II).

Dated at _____, 20____
 (City) (State) (Mo.) (Day)

Signature of Proposed Insured _____

Witness _____
 Must be examiner

Signature of Parent or Guardian _____

If Proposed insured under age 18

MEDICAL EXAMINER'S REPORT

(EXAMINERS ARE REQUESTED TO MAKE A VERY CAREFUL EXAMINATION OF HEART AND LUNGS WITH STETHOSCOPE AGAINST THE BARED SKIN.)
DO NOT ATTEMPT TO UNDERWRITE THE RISK — SIMPLY STATE THE FACTS.

6. a.	Height (In shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.		
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No							
7. Blood pressure (Record ALL readings)							
Systolic	4th phase						
Diastolic	5th phase						
		At Rest	After Exercise	3 Minutes Later			
8. Pulse:							
Rate							
Irregularities per min.							
9. 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		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </table>					
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"/>					
Systolic	<input type="checkbox"/>	<input type="checkbox"/>					
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>					
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:		For comments and your impression?					
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"/>					
10. Is there on examination any abnormality of the following: (Circle applicable items and give details.)							
a. Eyes, ears, nose, mouth; pharynx?		Yes	No				
		<input type="checkbox"/>	<input type="checkbox"/>				
(If vision or hearing markedly impaired, indicate degree and correction)							
b. Skin (incl. scars); lymph nodes, varicose veins, peripheral arteries, herpetic lesions, nevi, lumps or ulcerations?		<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"/>				
11. (a) Are there any hemias? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Any hemorrhoids?		<input type="checkbox"/>	<input type="checkbox"/>				
12. Are you aware of additional medical history?		<input type="checkbox"/>	<input type="checkbox"/>				
(A confidential report may be sent to the Medical Director)							

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

Examined at: applicant's residence on _____, 20____, at _____ a.m. _____ p.m.
 applicant's business
 examiner's office Signature of Examiner _____ M.D. or D.O. Paramedic

Examiners Social Security Number _____ Examiner's Address _____
 or Taxpayer Identifying Number _____ (Please print)

At request of _____, Agent Agency Address _____



LIFE INSURANCE COMPANY

Life Products • P.O. Box 5416 • Cincinnati, OH 45201-5416

EXAMINER'S NAME AND ADDRESS

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer has requested that you provide a sample of your blood 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 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.

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 other solely involved in the underwriting process. If the HIV test is positive the results will be reported to the local health department or the State Department of Health and if the insurer is a member of the Medical Information Bureau (MIB, Inc.), the Insurer may report the results in a generic code which signifies only non-specific blood 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 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 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 that 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 applications 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.



CALIFORNIA

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INFORMATION ON HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. If you need information about the availability of counseling in your area contact your county health department or see the attached list of counseling centers.

CONSENT

I have read and I understand this Notice and Consent For Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize the insurer to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Physician's Name: _____

Physician's Address: _____

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

Date of Birth

Signature of Proposed Insured
or Parent/Guardian

Date

State of Residence