

- Hartford Life Insurance Company
- Hartford Life and Annuity Insurance Company
Hartford, CT 06104-2999



MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

INSTRUCTIONS FOR THE MEDICAL EXAMINER — DETACH AND DISCARD BEFORE MAILING THE COMPLETED EXAMINATION TO THE COMPANY

- 1.) If you are related to the proposed insured being examined or to the agent, **PLEASE DO NOT PERFORM THIS EXAMINATION.** Please immediately advise the agent and the paramedical company so other arrangements can be made.
- 2.) Please perform the examination in private.
- 3.) **PLEASE RECORD ALL INFORMATION LEGIBLY IN YOUR OWN HANDWRITING, IN BLACK INK.**
- 4.) Please complete the Senior Exam Supplement (pages 5 and 6) on all applicants age 71 or over.
- 5.) Please cut the word flashcards (page 7) and arrange them in order as noted on the form prior to doing the Senior Exam Supplement.
- 6.) If there are any alterations or changes on pages 1, 2 or 3, the proposed insured being examined must initial them. If you have any alterations on page 4, you must initial them yourself.
- 7.) If you have any other medical information which may have a bearing on the insurability of this proposed insured, please list it on this exam questionnaire, or on a separate piece of paper and mail it with the examination to our Company.
- 8.) This examination, once begun, is the property of the Company. Please do not destroy or delay sending it to the Company
- 9.) Fees will be paid by the Company.



MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

PLEASE USE BLACK INK ONLY

1) Name of Proposed Insured _____ Date of Birth _____
Residence (City and State) _____

2) Primary Physician, Health Care Provider or Clinic:
Name _____ Address _____

Phone Number _____
Date of Last Visit _____

Reason for Last Visit (Please include details of evaluation, treatment and/or referrals made.)

NOTE: GIVE DETAILS TO ALL "YES" ANSWERS ON NEXT PAGE

	Yes	No
3. Do you take any prescription, over the counter medication or herbal remedy? (If "Yes," please provide names and doses.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had, been treated for or had treatment recommended by a member of the medical profession for:		
a. High Blood Pressure; Heart Murmur or Heart Valve Abnormality; Chest Pain; Heart Surgery; Heart Attack; Abnormal Heart Rhythm; other Heart or Vascular Disease, Condition or Disorder; Stroke or Mini-Stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancer, Tumor or other abnormal growth; Recurrent Infections; Lymph Gland Swelling or Enlargement; Immune System Disease, Human Immunodeficiency Virus (HIV) Infection, or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes or other Endocrine Disease; Condition or Disorder (e.g. thyroid, adrenal, pituitary, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Anemia; Blood Transfusion; Blood Vessel Disease; other Blood Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Dizziness; Fainting or Loss of Consciousness; Alzheimer's Disease or Dementia; Epilepsy or Seizure Disorder; Brain or Spinal Cord Disorder; other Nervous System Disease; Depression, Anxiety, Stress or Panic Attacks; or other Psychological Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Asthma, Chronic Bronchitis or Emphysema; other Lung Disease, Condition or Disorder; Sleep Apnea or Narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>
g. Disease of the Esophagus, Pancreas or Stomach; Ulcerative Colitis or Crohn's Disease; Chronic Indigestion, Diarrhea or Vomiting; Hepatitis or other Disease of the Liver; Hernia, other Gastrointestinal Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Bladder Disease; Kidney Disease; Prostate Disease; Sugar, Protein or Blood in the Urine; Breast Disease; other Genitourinary Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Rheumatoid Arthritis, Lupus, other Connective Tissue Disease, Condition or Disorder; Arthritis, Rheumatism or other Joint Disease, Condition or Disorder; Disease, Condition or Disorder of Bones, Back or Spine; Disease, Condition, or Disorder of Muscles, Ligaments or Tendons?	<input type="checkbox"/>	<input type="checkbox"/>
j. Ear Disease or Eye Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k. Chronic Fatigue, Fibromyalgia or Myalgia?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you engage in regular exercise? (If "Yes," provide details).	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you lost 10 or more pounds in the last 6 months (not due to change in diet)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you, in the past 5 years, used any illicit drug or prescription drug that was not prescribed by a physician? (If "Yes," provide details to include treatment recommended or given.)	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you currently consume alcoholic beverages? (If "Yes," how many per day and per week?)	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
12. Females only: Are you currently pregnant? (If "Yes," what is your due date?)	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>



SENIOR EXAM SUPPLEMENT

Instructions for the examiner:

PLEASE COMPLETE FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

- | | |
|-----|--|
| 1a. | <p>Read aloud the instructions below to the Proposed Insured. Then read aloud each of the words on the list, one at a time, while showing the corresponding flashcard, and ask the proposed insured to make up a sentence using each word. The proposed insured may not record anything on paper. It is not necessary to record the proposed insured's response; draw a line through any word that the proposed insured cannot use in a sentence.</p> <p><i>In this part of the survey, I will read a word while showing the word to you. Please use each word in a sentence. The sentence may be as long or as short as you like. Later I am going to ask you to recall the words. Do you have any questions?</i></p> |
| 1b. | <p>Follow the same instructions as for Part a. Read aloud the instructions below. When done, place the flashcard out of sight. Note the time and allow at least 5 but not more than 15 minutes before proceeding to #6.</p> <p><i>Now I am going to repeat the same words as before, show you the words and again ask you to use each in a sentence. You may make up a new sentence or use the same sentence that you used before. Do you have any questions?</i></p> |
| 2. | <p>Read instructions to the proposed insured and record number of seconds/minutes it takes to complete the task. The proposed insured must stand up from a seated position without using the arms of the chair for help, walk 10 feet, turn around and sit down.</p> <p><i>Please complete this exercise: Stand up without using the arms of the chair, walk to <u>(insert place in the room that is 10 feet away)</u>, turn around, walk back, and sit down.</i></p> |
| 3. | <p>Ask the proposed insured about the activities listed. Record details of answers, giving specifics of activities they do perform and reasons for ones they are unable to perform or able to perform only with assistance.</p> |
| 4. | <p>Ask the proposed insured if they perform any regular exercise. Record details, including duration and frequency.</p> |
| 5. | <p>Record details of any falls, including circumstances, injuries, and treatment.</p> |
| 6. | <p>Read instructions to the proposed insured. <u>Record all words, including words not on the list that the applicant recalls.</u> DO NOT read the words to the proposed insured; this must be done from memory. AT LEAST 5 MINUTES BUT NO MORE THAN 15 MINUTES MUST HAVE ELAPSED FROM PARTS 1a AND 1b BEFORE DOING THIS ACTIVITY.</p> <p><i>A few minutes ago I read some words to you and you used them in sentences. Please repeat to me as many words as you can recall.</i></p> |
| 7. | <p>Read the instructions to the proposed insured. Allow 60 seconds for the task. Straight edge or ruler is not allowed.</p> <p><i>Please duplicate the following drawing.</i></p> |

Upon completion of the examination, provide any additional information or observations within the details section of the answer page. Verify that the client name and date of birth, and your signature are on the Senior Supplement. Return the answer page with the other examination paperwork. Discard this instruction page and the flashcards prior to mailing any and all examination paperwork or specimens.



SENIOR EXAM SUPPLEMENT

PLEASE COMPLETE THE FOLLOWING FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

Name of Proposed Insured:

Date of Birth:

1a. Follow the instructions for question 1a. Draw a line through any word below that the proposed insured cannot use in a sentence:

Book Flower Train Rug Meadow
 Salt Finger Park Chimney Button

DETAILS SECTION: Please indicate the question number and all details below.

1b. Please repeat the task in 1a exactly, using the words in the same order.

Book Flower Train Rug Meadow
 Salt Finger Park Chimney Button

2. Please ask the proposed insured to stand up, not using the arms of the chair, walk 10 feet, turn around, walk back and sit down. Record the amount of time from start to finish: _____

3. Is the proposed insured able to do the following without assistance? Record details at right.

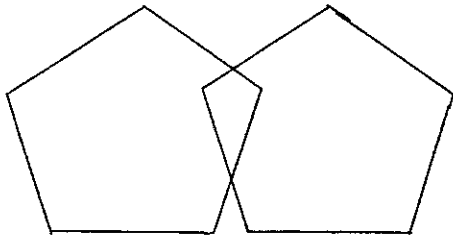
- A. Clean home, do yard work? Yes No
- B. Shop (food, clothes, etc.)? Yes No
- C. Drive, travel? Yes No
- D. Manage finances (pay bills, balance check book, etc)? Yes No

4. Does the proposed insured engage in any type of regular exercise (walking, treadmill, running, aerobics, swimming, strength training, etc.)? Record details at right. Yes No

5. Has the proposed insured fallen at any time in the last 2 years? Record details at right. Yes No

6. Please ask the proposed insured to repeat as many words as they can recall from #1 above. Record responses to the right.

7. Please ask the proposed insured to draw the figure below in the space at the right.



I certify that I have personally asked all of the questions and accurately recorded responses and results.

Signature of examiner

Date

Print name of examiner

Book

Salt

Flower

Finger

Train

Park

Rug

Chimney

Meadow

Button

HARTFORD LIFE INSURANCE COMPANIES
Individual Life Operations
P.O. Box 64271
St. Paul, Minnesota 55164-0271
Telephone Number: (800) 246-4819



Information Statement
Information/Consent Regarding Blood Or Other Bodily Fluid Sample Testing
Important Information About Blood Or Other Bodily Fluid Sample Testing
Before consenting to testing, please read the following important information.

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

1. **Description of Tests to be Performed.** A blood or other bodily fluid sample is drawn for the purpose of laboratory testing to provide medical information concerning your insurability. These tests may include but are not limited to tests for: infection by the HIV virus; immune disorders; cholesterol and related blood lipids; diabetes; liver or kidney disorders; or the presence of medication, drugs, nicotine or other metabolites.

When HIV testing is performed, it will be performed according to the medical protocols required by Section 799 of the California Insurance Code.

2. **Purpose.** An HIV test is done to determine whether you may have been infected with the HIV virus. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation. If you have a positive ELISA test followed by a positive Western Blot Assay performed on the same specimen of blood or other bodily fluid sample, your life insurance application may be declined.
3. **Potential Uses.** If your HIV test results are positive, the company with whom you are applying for insurance will report a "nonspecific abnormality" of your blood or other bodily fluid sample to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other blood or bodily fluid sample abnormalities are reported to the Bureau under the same classification.
4. **Limitations.** An HIV test is considered positive only when conducted according to the protocol specified by Section 799 of the California Insurance Code. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. False positives. The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
5. **Meaning of the Test Results.** While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. If your blood or other bodily fluid sample is tested for HIV antibodies and if your test results are positive, the company with whom you are applying for insurance will notify the physician designated on Page 3 to whom you have authorized disclosure and with whom you may discuss the results. Positive HIV antibody test results will adversely affect your insurance application.

6. **Disclosure of Test Results.** All test results may be treated confidentially. Test results will be reported to the company with whom you are applying for insurance. The results may be reported to the company's affiliates, reinsurers, or contractors in connection with insurance you have or have applied for. In addition, if your HIV antibody

test is positive, a generic code signifying a nonspecific blood or bodily fluid sample abnormality will be reported to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

7. **Confidentiality of Test Results.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application.
8. **Notice of Available Counseling Resources.** The California Code requires that a list of counseling resources be made available, where the applicant can obtain assistance in understanding the meaning of the test and its results. There are many counseling resources in your area for you to contact. Below are samples of some of the many counseling resources:

Valley Aids Project
4341 Railroad Ave #H
Pleasanton, CA
(925) 485-3260

Aids Project Los Angeles
1313 Vine Street
Los Angeles, CA 90028
(323) 993-2300

Aids Project of The East Bay
1755 Broadway Fl 2
Oakland, CA
(510) 663-7979

Aids Project Monterey County
12 E Gabilan Street
Salinas, CA
(831) 772-8200

Aids Health Care Foundation
8631 W 3rd St.
Los Angeles, CA
(310) 657-9353

Aids Emergency Assistance
2440 3rd Avenue
San Diego, CA
(619) 544-0221

San Francisco Aids Foundation
1 6th Street
San Francisco, CA
(415) 487-3000

Being Alive
4068 Centre St.
San Diego, CA
(619) 291-1400

Aids Benefit Counselors
973 Market Street
San Francisco, CA
(415) 777-0333

Santa Monica Aids Project
2020 Santa Monica Boulevard
Santa Monica, CA 90404
(310) 652-7627

AIDS HOTLINE
Us. Public Health Service
(800) 342-AIDS
(800) 922-AIDS (Southern CA)

Sacramento Aids Foundation
2411 F Street Apt. 5
Sacramento, CA 95814
(916) 448-2437

California Department of Health Services
Statewide Services – Office of AIDS
(916) 323-7415

Spanish AIDS Hotline
(800) 222-AIDS

9. **Printed Material about HIV.** By my signature on Page 3, I acknowledge receipt of a copy of the American Red Cross pamphlet "AIDS: The Facts" (AIDS-1) before executing the following CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION.



CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION

I give my consent to the company with whom I am applying for insurance, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

1. Blood test or other bodily fluid testing for antibodies to the AIDS Virus (HIV).
2. Such other or additional blood or other bodily fluid sample tests which the company with whom I am applying for insurance may lawfully order.

My consent to this testing is freely given, based on the following understandings:

1. The purpose of the test(s) is to determine whether I am insurable for life insurance.
2. I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood or other bodily fluid sample tested and by refusing to give a blood or other bodily fluid sample. I know that if I do not take the test(s), my application to the company with whom I am applying for life insurance will be declined.
3. The test(s) for the antibodies to the AIDS virus (HIV) (or other test(s) permitted by law) will be conducted following approved test protocols.
4. I designate the following physician to receive notice of positive test results:

Physician's Name

Telephone Number

Street

City, State, Zip Code

(If no physician is designated, we will notify you directly, but we strongly urge you to designate a physician.)

I further understand that test results will not be released or disclosed to any party (other than the company with whom I am applying for insurance and related parties identified above, to whom I hereby authorize disclosure) unless:

- a. I expressly authorize their release in writing; or
- b. A public health reporting law required disclosure; or
- c. A court order required disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

5. I understand that the company with whom I am applying for insurance may report to the Medical Information Bureau (MIB) any abnormal blood or other bodily fluid sample test, but, in case of a positive HIV antibody test, the company with whom I am applying for insurance will not disclose the type of blood or other bodily fluid sample test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I acknowledge receipt of a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured

Signature of Proposed Insured

Address of Residence of Proposed Insured

Date

City, State, Zip Code

Signature of Examiner/Agent

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER