

- 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

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|-----|--|
| 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</u> that the applicant recalls. 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 INSURED 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.

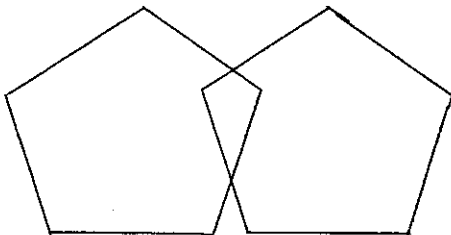
- A. Clean home, do yard work? Yes No
- B. Shop (food, clothes, etc.)? Yes No
- C. Drive, travel? Yes No
- D. Manage finances (pay bills, balance check book, etc)? Yes No

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



HIV ANTIBODY TESTING CONSENT FORM

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" 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 abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-852-AIDS.

HARTFORD LIFE INSURANCE COMPANIES
Individual Life Operations
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HIV ANTIBODY TESTING CONSENT FORM (Cont'd.)

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he/she can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or entity:

Name of Physician or other person/entity		

Street Address		

_____	_____	_____
City	State	Zip

Informed Consent

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured

Date of Birth

State of Residence

Date Signed by Proposed Insured

Signature of Witness

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER