

1. All questions must be read carefully to the proposed insured and full answers recorded in ink.
2. The medical examiner will complete Part 2 and the reverse side (Part 3) of this form when medical examination is made. All medical examinations, even those partially completed, must be forwarded by the agent to the Home Office.
3. If application is submitted non-medically, the agent will complete Part 2.
4. Fees for examinations will be paid from the Home Office only.

ILLINOIS MUTUAL LIFE INSURANCE COMPANY - 300 S.W. Adams Street, Peoria, Illinois 61634				
Application Part 2 - Statements to Medical Examiner, or Company's Agent, if non-medical case.				
1. (Print) First Name	Middle Initial	Last Name	(b) Been a patient or confined in any hospital, clinic, sanitarium or any other medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Birth date	Month	Day	Year	(c) Had an electrocardiogram, stress test, echocardiogram, angiography, x-ray, blood studies or other diagnostic test? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever:	Yes	No	(d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(a) Been discharged or deferred from armed services for a physical, mental or other reason?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you ever:	
(b) Had life, health or accident insurance declined, postponed or offered differently than applied for? If yes, give date, company and reason.	<input type="checkbox"/>	<input type="checkbox"/>	(a) Had or been told by a medical practitioner he/she had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) Claimed benefits for sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Received treatment in connection with any of the categories mentioned in (a) above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) Been treated, counseled or joined a group due to drug or alcohol use or abuse or been advised by a medical practitioner to do so?	<input type="checkbox"/>	<input type="checkbox"/>	(c) Tested positive for antibodies to the AIDS virus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(e) Used heroin, cocaine, barbiturates or other controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you had any parent, brother or sister who has had cancer, heart trouble, stroke, high blood pressure, diabetes or tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you ever had or been told that you had or been treated for:			8. (a) Have you smoked cigarettes during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(a) Disorder of the back, muscles, knees, bones or joints, gout or arthritis, deformity or amputation?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Do you use any other tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) High blood pressure, heart murmur, chest pain, heart attack, angina, stroke, rheumatic fever, varicose veins, phlebitis, coronary artery disease or any other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	9. What is your: (a) Height and Weight ____ ft. ____ in. ____ lbs.	
(c) Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	(b) Amount of gain or loss in weight in past year? _____	
(d) Brain or nerve disease, dizziness, fainting, convulsions, headaches, unconsciousness, paralysis, mental disease or nervous disorder including emotional problems, anxiety, depression or psychiatric treatment or counseling?	<input type="checkbox"/>	<input type="checkbox"/>	Give full details of Questions 3-8 answered "Yes." Specify dates, duration, severity, results, the names and addresses of any physicians, hospitals, etc. Indicate number of question to which details apply.	
(e) Shortness of breath, persistent or chronic cough, asthma, chronic bronchitis, emphysema or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
(f) Hepatitis, jaundice, ulcer, hernia, colitis, recurrent diarrhea, rectal disease or disorder of the stomach, intestines, liver, gall bladder, pancreas or spleen?	<input type="checkbox"/>	<input type="checkbox"/>		
(g) Sugar, blood or albumin in urine; sexually transmitted or venereal disease, kidney stone; disorder of bladder, prostate, kidney, reproductive organs, or any other disorder of the generative or urinary system?	<input type="checkbox"/>	<input type="checkbox"/>		
(h) Diabetes, thyroid or other glandular disorders?	<input type="checkbox"/>	<input type="checkbox"/>		
(i) Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>		
(j) Disorder of the skin or lymph glands; allergy?	<input type="checkbox"/>	<input type="checkbox"/>		
(k) Are you pregnant? If yes, expected date of delivery: _____	<input type="checkbox"/>	<input type="checkbox"/>		
(l) Have you ever had a Cesarean section or other complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have you during the past 5 years, other than as stated above:				
(a) Seen a physician, surgeon, chiropractor or other practitioner for a check-up, consultation, illness, injury or surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
I agree that the foregoing statements and answers are complete, true and correctly recorded and shall form Part Two of my pending application for insurance, and also of any subsequent application by me for insurance in this Company, unless I then undergo another medical examination which by its terms is made a part of such application and of subsequent applications. I expressly waive on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder all provisions of law forbidding any physician, hospital official or employee, or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto, and I expressly authorize such persons to make such disclosures, all to the extent permitted by law.				
Dated at _____ on _____		Signature of Proposed Insured		
Witness _____				

Form R202-01

This Authorization Should Be Signed In Every Case. Do Not Detach.

**Authorization**

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related health care facility or health care provider insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of me, my spouse or my minor children, to give to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as its original and agree that this Authorization shall be valid for two years from the date shown below.

Signature of Proposed Insured

Form 2046

**Medical Examiner's Report**

Application Part 3 -

10. How long have you known proposed Insured?

11. (a) Height \_\_\_\_\_ ft. \_\_\_\_\_ in.  
 Weight \_\_\_\_\_ lbs. Did you weigh?  Yes  No  
 (b) Chest at inspiration \_\_\_\_\_ in.  
 (c) Chest at expiration \_\_\_\_\_ in.  
 (d) Girth of abdomen \_\_\_\_\_ in.  
 (e) Any weight change in past year?  Yes  No  
 If Yes, state amount and cause under "Details."

12. Do you find evidence of past or present disease or abnormality of the following? Yes No

(a) Eyes, Ears, Nose, Throat (Measure markedly impaired vision, corrected and uncorrected.) State if hearing aid used.	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin, Thyroid or other Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>
(c) Lungs or Pleurac	<input type="checkbox"/>	<input type="checkbox"/>
(d) Abdominal Organs (including Hernia)	<input type="checkbox"/>	<input type="checkbox"/>
(e) Musculoskeletal System (Any deformity?)	<input type="checkbox"/>	<input type="checkbox"/>
(f) Vascular System (Any Varicose Veins?)	<input type="checkbox"/>	<input type="checkbox"/>
(g) Nervous System (Any tremor or abnormal reflexes?)	<input type="checkbox"/>	<input type="checkbox"/>

13. Blood Pressure: (If above 140/90, report additional readings.)

Systolic					Hour	Time
Diastolic 5th phase						

14. Pulse:

	Resting	Reaction to Exercise		
		Before	Immediately After	3 Minutes After
Rate				
No. Irregularities per minute				
Type of irregularity?				

NOTE: If resting pulse 90 or over and/or irregular and if proposed Insured is able to exercise and there is no health risk, complete Reaction to Exercise portion.

15. Heart:

(a) Is heart enlarged?  Yes  No  
 (b) Is there a murmur?  Yes  No  
 (c) The murmur is -

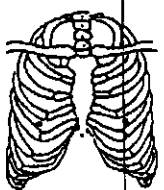
Type:	Quality:	Intensity:	Location:
<input type="checkbox"/> Systolic	<input type="checkbox"/> Soft	<input type="checkbox"/> Faint (1-2)	<input type="checkbox"/> Apex
<input type="checkbox"/> Diastolic	<input type="checkbox"/> Rough	<input type="checkbox"/> Med. (3-4)	<input type="checkbox"/> Aortic
<input type="checkbox"/> Presystolic	<input type="checkbox"/> Blowing	<input type="checkbox"/> Loud (5-6)	<input type="checkbox"/> Pulmonic

(d) Transmission -  
 None  To neck  
 To axilla  Elsewhere

(e) The murmur is:  Constant  Inconstant

(f) Murmur heard best in which position?  
 Erect  Recumbent  
 Left lateral

(g) Indicate on diagram:  
 Apical impulse (x)  
 PMI (o)  
 Transmission (→) area of murmur by outline (---)



(h) What effect does exercise have on murmur? \_\_\_\_\_

(i) Your diagnosis and/or comment: \_\_\_\_\_

16. Urinalysis: Microscopic examination is required in all cases. Please send specimen to:

LabOne, Inc.  
 10101 Renner Blvd.  
 Lenexa, KS 66219-9732

Give full details of any "Yes" answers and add any other pertinent information or comments.

YOU MAY SEND CONFIDENTIAL INFORMATION DIRECTLY TO THE MEDICAL DIRECTOR.

I certify that I have made this examination with the results recorded on this \_\_\_\_\_ day of \_\_\_\_\_.

in private at:  My Office  
 Applicant's residence  
 Applicant's place of business

X \_\_\_\_\_  
 Examiner's Signature

Form R202-01

DO NOT DETACH THIS VOUCHER.

**MEDICAL EXAMINER'S VOUCHER**

TO ASSURE PROMPT PAYMENT OF YOUR FEE THIS VOUCHER SHOULD BE FULLY COMPLETED.

Name and Address of Examiner	Please Print or Rubber Stamp	Date of Exam.	Mo.	Day	Yr.	Agent
Your fee \$ _____		Please give Tax I.D. No. Individual Practitioners - SS No. Employer I.D. No.				
Name of Person Examined		Please Print				

Form 1723