



P.O. Box 4905  
Des Moines, IA 50306-3590  
Fax: 1-800/531-0038



P. O. Box 14590  
Des Moines, IA 50306-3590  
Fax: 1-888/329-1329

## Application For Insurance Medical Examination Part 1

Please check appropriate company. **ONE BOX MUST BE CHECKED.**  
(In this application, "Company" refers to the insurance company whose name is checked above.)

Name of Proposed Insured	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date ____/____/____ month      day      year
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Social Security Number	Name of Agent
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### MEDICAL HISTORY RECORDED BY EXAMINER (answers are to be handwritten by examiner)

- (a) Name and address of your doctor(s) or health care provider(s): \_\_\_\_\_  
(if none, so state) \_\_\_\_\_
- (b) When did you last consult a doctor and why? \_\_\_\_\_
- (c) Are you now under observation or treatment?  Yes  No  
(if Yes, describe) \_\_\_\_\_
- (d) What medication(s) (prescribed or over the counter) are you now taking? \_\_\_\_\_  
(if none, so state) \_\_\_\_\_

### 2. IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION FOR:

- Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain?  Yes  No
- Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test?  Yes  No
- Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps?  Yes  No
- Diabetes, thyroid, glandular or endocrinal disorder?  Yes  No
- Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray?  Yes  No
- Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis?  Yes  No
- Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine?  Yes  No
- Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting?  Yes  No
- Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder?  Yes  No
- Anemia, hepatitis, or any blood disorder (except HIV status)?  Yes  No
- Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease?  Yes  No

### 3. Have you ever:

- been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related condition)?  Yes  No
  - tested positive for HIV antibodies as part of a test for obtaining insurance?  Yes  No
4. In the past 10 years, have you requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury or sickness?  Yes  No
5. Within the last 5 years, other than as reported in sections 1 - 3, have you:
- Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed?  Yes  No
  - Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal?  Yes  No

DETAILS FOR YES ANSWERS - give the question number - circle applicable item. Include: 1. Nature and severity, frequency of attacks, specific diagnosis and treatment; 2. Dates and duration; 3. Name and address of each physician and hospital.



\* 1 4 5 8 1 0 4 0 2 0 1 \*

6. Within the last 5 years have you:

- a. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? .....  Yes  No
- b. Used or are you currently using alcoholic beverages? .....  Yes  No
- If yes, complete the following: # of times per month # per occasion Kind of beverage
- \_\_\_\_\_

Check here  if additional medical history or details have been recorded on page 4 or on an attachment and have the Proposed Insured date and sign that part of the form or the attachment.

7. a. Have any of your parents, brothers or sisters been diagnosed with diabetes, cancer, heart disease, or any hereditary disorders prior to age 60? .....  Yes  No
- b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

8. a. Do you exercise regularly (aerobic, calisthenic, jogging or running, swimming)? .....  Yes  No
- If Yes, describe and state how often \_\_\_\_\_
- b. Do you use any form of tobacco or nicotine based products? .....  Yes  No
- If no, have you used any form of tobacco or nicotine based products in the past 5 years? .....  Yes  No
- If yes, when did you last use tobacco or nicotine based products? \_\_\_\_\_
- Type \_\_\_\_\_ Quantity \_\_\_\_\_

It is represented that the answers and statements on this application are complete and true and correctly recorded.

I agree that a copy of this application shall be a part of the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmaceutical database, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me including information about drug use, alcoholism, AIDS or ARC (AIDS-related condition), or mental illness and any other non-medical information about me to give to the Company, its reinsurers or its authorized representatives any such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I agree that this authorization shall be valid for 2 years from the date shown below and that a photographic copy of this authorization shall be as valid as the original.

Signed/Dated at \_\_\_\_\_  
City, State

X \_\_\_\_\_  
Signature of Examiner

On \_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Proposed Insured



# Physical Examination Report

## Part 2

1. (a) Measured height (in shoes) \_\_\_\_\_ feet \_\_\_\_\_ inches  
 (b) Scale Weight (clothed) \_\_\_\_\_ pounds  
 (c) Measurement (Males Only) – Chest Full Inspiration \_\_\_\_\_ inches  
 – Chest Forced Expiration \_\_\_\_\_  
 – Waist Measurement \_\_\_\_\_  
 – Hip Measurement \_\_\_\_\_

2. Blood Pressure  
 arm sitting - take 2 readings and record both. If a reading is higher than 140/90, record 2 more readings at end of examination.

	(a) INITIAL READINGS		(b) LATER READINGS	
Systolic				
Diastolic (5th phase)				

3. Cardiac

(a) PULSE

rate per minute	describe irregularities and give number per minute
at rest sitting .....	

at rest sitting .....

If lowest pulse rate is over 90, record an at-rest rate at end of examination here: .....

(b) HEART FINDINGS - Auscultate all valve areas

Any murmur?	Any other irregularity - PVC, clicks or gallup?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If murmur heard, describe in 4.	Describe:

4. Description of Heart Murmur

- (a) Location:  Apical  Aortic  Pulmonic \_\_\_\_\_  
 (b) Timing:  Holosystolic  Midsystolic  Diastolic  
 (c) Character:  Rough  Blowing  Other \_\_\_\_\_  
 Grade 1-2  3-4  5-6  
 (d) If transmitted, where? \_\_\_\_\_  
 (e) Is murmur heard: Left Lateral? \_\_\_\_\_ Supine? \_\_\_\_\_  
 Sitting? \_\_\_\_\_ Standing? \_\_\_\_\_  
 (f) Does squatting or valsalva maneuver affect the murmur?  Yes  No  
 (g) If more than 1 murmur, describe separately here:  
 (h) Your diagnosis of murmur(s):

5. Other Cardiac Findings – Is/are there any:

- (a) evidence of cyanosis, clubbing, dyspnea, edema or enlargement? .....  Yes  No  
 If enlarged give location of left border:  
 (b) carotid bruit or absence of pedal pulses? .....  Yes  No  
 (c) abnormality of veins? .....  Yes  No  
 (d) any other cardiac abnormality? .....  Yes  No  
 (e) If any above are Yes, what is your diagnosis or opinion?

6. General Examination – Is there any abnormality of:

- (a) ears or eyes? .....  Yes  No  
 (b) nose, mouth, throat or lungs? .....  Yes  No  
 (c) skin, musculoskeletal system or amputations? .....  Yes  No  
 (d) neurologic system (include paralysis, reflexes)? .....  Yes  No  
 (e) endocrine or lymphatic systems? .....  Yes  No

Comment on abnormal findings in section 9.



7. Was an interpreter used to complete this form if the Proposed Insured cannot speak or understand English? .....  Yes  No

Interpreter name \_\_\_\_\_ Relationship of Interpreter \_\_\_\_\_

8. Miscellaneous Information

(a) Are you aware of any additional medical history or findings? .....  Yes  No

(a confidential report may be made to the Company's Medical Director or details given in 9)

(b) Is appearance that of good health? (if No, describe in 9) .....  Yes  No

(c) Are you related to or have a business association with either the Proposed Insured or the Agent? (if Yes, describe in 9) .....  Yes  No

(d) Are you the Proposed Insured's personal physician? .....  Yes  No

If Yes, for how long? \_\_\_\_\_ years

9. Additional Medical History and Comments

10. Blood and Urine Specimens - should be based on the amount of insurance applied for

\$100,000 - up	draw blood samples and collect urine specimen using the provided blood kit and send kit (with blood and urine samples) to designated lab.
\$10,000 - \$99,999	collect urine specimen and send to designated lab in provided specimen container.

Indicate handling:  blood and urine sent to lab.  EKG tracing attached  
 urine only sent to lab.

I certify that I have questioned and examined the Proposed Insured.

\_\_\_\_\_ of \_\_\_\_\_  
Print name in full Address (City and State) of Proposed Insured

Date of exam: \_\_\_\_\_ time of exam: \_\_\_\_\_  AM  PM Place of exam: \_\_\_\_\_

**X**  
\_\_\_\_\_  
Signature of examiner

Please be sure the Proposed Insured has signed Part 1 and the examiner has signed both Parts 1 and 2.

FEE Information. Send fee to:  
  
(please use stamp or print legibly, include taxpayer no.)

Please see Company instructions for mailing.

A \$75 fee for this insurance examination will be paid upon receipt.

If any additional studies required by the Company were done, indicate what was done and send tracing or film with the exam form.  EKG Fee: \$50  Treadmill \$300  
Print name in full Address (City and State) of Proposed Insured

Date of exam: \_\_\_\_\_ time of exam: \_\_\_\_\_  AM  PM Place of exam: \_\_\_\_\_

**X**  
\_\_\_\_\_  
Signature of examiner





AmerUs Life Insurance Company  
P.O. Box 4905  
Des Moines, IA 50306-4905



Indianapolis Life Insurance Company  
P.O. Box 14590  
Des Moines, IA 50306-3590

### NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the company named above (the Company) may request that you provide a specimen 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.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA test will be done.
  - a) If the initial ELISA test is reactive or indeterminant, it will be repeated.
  - b) If the initial ELISA test is nonreactive, a negative finding will be reported to the Company.
2. If the second ELISA test is also reactive or indeterminant, a Western Blot test will be performed to confirm the results of the two ELISA tests.
  - a) If the second ELISA test is nonreactive, a third ELISA test will be performed. If the third ELISA test is reactive or indeterminant, a Western Blot test will be performed to confirm the previous results. If the third ELISA test is nonreactive, a negative result will be reported to the Company.
3. Only if at least two ELISA tests and a Western Blot test are all reactive or indeterminant will the result be reported as such. All other results will be reported as negative to the Company.

#### Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application 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.

#### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to other persons or organizations performing business or legal services for the Insurer. The results may

be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

#### Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported as being reactive or indeterminant, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician below so that the Company can have him or her tell you the test result and explain its meaning. In the event the test is other than nonreactive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

#### Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to provide a specimen, the testing of that specimen, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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. This consent shall be valid for 90 days from the date below.

Name and address of physician for reporting a possible positive test result:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

Date Signed: \_\_\_\_\_