

PART 2 OF APPLICATION



Industrial-Alliance Pacific Life Insurance Company,
United States Branch
Box 8118, Blaine, WA 98231-8118
Tel: (425) 646-6467 Fax: (604) 682-2013

1. Name of Proposed Insured: _____ Date of Birth: _____ Sex: M F

2. a) Name and address of your usual physician or medical facility:

b) Date and reason last consulted: _____

c) Results, diagnosis and or treatment prescribed: _____

3. In the past ten years have you had, been tested for, received treatment or counseling from a medical professional for;	Yes	No	Details of "YES" answers. Please identify applicable question and include dates, diagnosis, duration, treatment as well as the full name and address of all physicians and medical facilities.
a) Dizziness, fainting, convulsions, seizures, epilepsy, speech disorder, paralysis, stroke or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Depression, anxiety, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Shortness of breath, bronchitis, emphysema, tuberculosis, asthma, spitting of blood, pleurisy or persistent cough?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
d) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Rheumatic fever, heart murmur, heart valve disorder, edema or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
f) Ulcer, intestinal bleeding, colitis, Ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis or any disorder of the stomach, intestines, spleen, liver or rectum?	<input type="checkbox"/>	<input type="checkbox"/>	
g) Diabetes, high blood sugar or sugar in your urine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
h) Blood cells, albumin or protein in your urine, any disorder of the kidneys, bladder, prostate, or urinary system?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
i) Venereal disease or any disorder of the reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
j) Thyroid, thymus, pituitary or lymph gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
k) Cancer, sarcoidosis, tumor or any abnormal growth?	<input type="checkbox"/>	<input type="checkbox"/>	
l) Back pain, sciatica, neuritis, rheumatism, arthritis, muscular dystrophy or any disorder of the muscles, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	
m) Multiple sclerosis, or any disorder of the brain or spinal cord?	<input type="checkbox"/>	<input type="checkbox"/>	
n) Hemophilia, sickle cell anemia, anemia or any disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
o) Alcoholism or excessive use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	

4. In the past ten years have you:
a) been diagnosed or treated by a physician or other health care professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) or positive test results indicating the presence of the AIDS virus?
 Yes No

5. Have you used any form of Tobacco or nicotine products:	Yes	No	Details of "YES" answers. Please identify applicable question and include dates, diagnosis, duration, treatment as well as the full name and address of all physicians and medical facilities.
a) In the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>	
b) In the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you ever used marijuana, hash, cocaine, heroin or narcotics not prescribed to you by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Other than the above, within the past 5 years, have you had:			
a) An examination or treatment by a doctor or medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Observation or treatment at a clinic, hospital or other facility?	<input type="checkbox"/>	<input type="checkbox"/>	
c) An EKG, stress test, xray, blood test or any other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	
d) A surgical operation or been advised to have a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>	
e) A change of weight, anorexia nervosa or bulimia?	<input type="checkbox"/>	<input type="checkbox"/>	
8. a) If female, are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever had any complications with this or previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Any disorders of the breast?	<input type="checkbox"/>	<input type="checkbox"/>	
9. a) Do you have a family history of Diabetes, Cancer, Stroke, Kidney disease, high blood pressure, Coronary artery disease, Huntington's Chorea, alcoholism, drug abuse or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you ever received disability benefits from any source?	<input type="checkbox"/>	<input type="checkbox"/>	

I hereby declare that the answers and statements contained in this Part 2 application are full, complete and true to the best of my knowledge and belief and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 application shall be part of my application for insurance and will form part of the policy contract.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

Signed at: _____ Date: _____
 City, State/Province

Witness: _____ Proposed Insured: _____
 Signature of examiner

MEDICAL EXAMINERS REPORT

YES NO

All Proposed Insureds must be weighed and measured.

10. a) Height: []
b) Weight: []
Weight change in past year? []
Gain Loss
Cause? []

11. Blood pressure
Systolic 1 [] 2 [] 3 []
Diastolic 1 [] 2 [] 3 []
If blood pressure is over 140/90 take 3 readings at least 5 minutes apart.

12. Pulse []
Rhythm []
Irregularities? []
If pulse is over 90, repeat in 5-10 minutes

13. Urinalysis:
Please indicate test results in the space provided.
(This section to be completed on all examinations)
Albumin []
Glucose []
Blood []
Please forward urine sample to LABONE for microunalysis.

14. Does the Proposed Insured appear older than the stated age?
Yes No

15. Is there any evidence of alcohol, drug or nicotine addiction?
Yes No

16. Any evidence of past or present disease of:
a) The brain or nervous system? (Test reflexes and coordination)
b) Head or neck? (Including ears, eyes and mouth)
c) Endocrine system, breast or glands?
d) Chest and lungs? (Examine on bare chest with expiratory cough)
e) Heart and blood vessels?
f) Abdomen? (Liver, spleen, abnormal masses, tenderness, surgical scars)
g) Genito-Urinary system? (Include prostate)
h) Muskuloskeletal system? (Include spine joint, deformities)
i) Skin (Xanthomas, nevi etc.), lymph nodes?

17. Is there:
a) Evident arteriosclerosis?
b) Cardiac hypertrophy?
c) Cyanosis, dyspnea or edema?
d) Cardiovascular impairment?
e) Any hernias or varicocities?
f) A heart murmur? (Complete heart chart)

18. Heart Chart
Murmur
Location: Apical Aortic Mitral Pulmonic
Timing: Systolic Diastolic Pre-systolic
Intensity: Soft Moderate Loud
Grade I II III IV V VI
Is murmur constant? Yes No
Transmitted? Yes No

If transmittes indicate where to: []
Effect of exercise: Unchanged Decreased Increased Disappears
Your Impression of murmur: []

Mail exam to:
Industrial-Alliance Pacific Life Insurance Company
P.O. Box 8118
Blaine, WA 98231-8118

19. Did you require an interpreter to question the Proposed Insured? Yes No

If yes, indicate interpreters' name and relationship to Proposal Insured _____

20. How was client identified? (Driver licence etc.) _____



I certify that I made this examination at Proposed Insureds home
 Office
 Other _____

Signed at: _____
City

Date: _____
M T W T F S S

Time: _____

Signature of examiner