

APPLICATION PART II - MEDICAL EXAMINATION

Administrative Office:
 ING Service Center
 2000 21st Ave. NW
 Minot, ND 58703

- ReliaStar Life Insurance Company, Minneapolis, MN
- Security Life of Denver Insurance Company, Denver, CO

Name of Proposed Insured _____ Date of Birth _____ SSN _____

Name of personal physician or clinic _____ Telephone Number _____

Address of personal physician or clinic _____

Date last consulted _____ Reason for, and results of consultation _____

1. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having:

	Yes	No
a. Dizziness, fainting, seizures, convulsions, optic neuritis, headache, paralysis, stroke, TIA, mental or nervous disorder, including anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, emphysema, tuberculosis, or chronic respiratory disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Sugar, albumin, blood or pus in urine, sexually transmitted disease, nephritis, stone, or other disorder of kidney, bladder, breasts, prostate, or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes, thyroid, or other endocrine disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Disorder of the skin or lymph glands, arthritis, or disorder of the muscles, joints or bones?	<input type="checkbox"/>	<input type="checkbox"/>
h. Anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
i. Positive HIV (Human Immunodeficiency Virus) test, AIDS (Acquired Immunodeficiency Syndrome), or other disease or disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you:

a. Experienced any symptom(s) for which you have not yet consulted a health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had any operation(s) in the past 10 years?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests not yet performed?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Sought or been advised to seek advice or treatment for the use of alcohol? (If "Yes", complete Alcohol Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
f. In the past 10 years been confined for observation, care, or treatment in a hospital or other health care facility?.....	<input type="checkbox"/>	<input type="checkbox"/>
g. In the past 5 years consulted any health care provider(s), not already identified, for any reason including routine physical examination?	<input type="checkbox"/>	<input type="checkbox"/>
h. Ever had a tumor, pre-cancerous lesion or cancer?	<input type="checkbox"/>	<input type="checkbox"/>

3. Are you:

a. Presently taking any medication(s), including non-prescription/over the counter medication or supplements?	<input type="checkbox"/>	<input type="checkbox"/>
b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? (If "Yes", complete Drug Use Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>

For any "Yes" answer to questions 1-3 please record information in chart below.

Qu. #	Condition	Diagnosis	Dates/Duration of Condition/ Treatment	Name of Doctor	Address of Doctor

4. Family History			
	Age if Living	Age at Death	Present Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

I have read the statements given in the examination and affirm that they are complete and true to the best of my knowledge and belief.

Signed at (City, State) _____ Date _____

Signature of the Proposed Insured (if age 15 or older) _____ Date _____

Signature of the Parent or Guardian (if the Proposed Primary Insured is a minor) _____ Date _____

Signature of Examiner _____ Date _____

MEDICAL EXAMINER'S REPORT

Provide further clarification in space provided below.

- 1a. How long have you known the Proposed Insured? _____
- b. Are you related to him/her or to the agent? ... Yes No
- 2a. Exact weight _____ b. Exact height _____
- c. Weight increase/decrease in last year _____
- d. Girth (males only)
Chest at forced expiration _____ Abdomen _____

3a. Blood Pressure: (Use right arm while seated. Two readings are recorded, none disregarded.) If systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 minutes of rest.

	1st	2nd	3rd	4th
Systolic				
Diastolic				

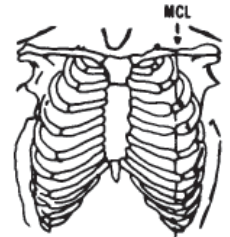
- b. Rate of Pulse _____
- 4a. Have the blood and urine specimens been sent?.. Yes No
- b. Lab ticket number _____
- c. Name of Lab _____
- 5. Was the EKG completed? (if required)..... Yes No
- 6. For females only.
 - a. Was the Proposed Insured menstruating at the time the urine specimen was voided? Yes No
 - b. Is the Proposed Insured pregnant? Yes No
- 7. Does the Proposed Insured currently use or has he or she ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches? Yes No
If "Yes", type and daily amount _____
Date last used _____
- 8a. Peripheral pulses: Normal Decreased
- b. Is there any irregularity or abnormality of the cardiac rhythm? Yes No
Nature of irregularity _____
Number of irregularities per minute _____
Number of irregularities after exercise _____

- c. Is there any abnormality of the quality or intensity of the heart sounds?..... Yes No
- d. Are there any heart murmurs?..... Yes No
If "Yes", diagnosis: Functional Organic
Type _____

Please indicate:

- | <u>Timing</u> | <u>Intensity</u> | <u>Quality</u> |
|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Systolic | <input type="checkbox"/> Faint | <input type="checkbox"/> Soft |
| <input type="checkbox"/> Presystolic | <input type="checkbox"/> Moderate | <input type="checkbox"/> Blowing |
| <input type="checkbox"/> Diastolic | <input type="checkbox"/> Loud | <input type="checkbox"/> Rough |

Indicate on diagram point of maximum intensity or murmur with O and direction of transmission with ➔



- e. Is the heart enlarged?..... Yes No
 - 9. Have you found any evidence of past or present disease of:
 - a. Head or neck?..... Yes No
 - b. Eyes, ears, nose or throat? Yes No
 - c. Lymph nodes?..... Yes No
 - d. Brain or nervous system? Yes No
 - e. Lungs or chest?..... Yes No
 - f. Abdomen? Yes No
 - g. Genito-urinary system? Yes No
 - h. Extremities or Peripheral vessels?..... Yes No
 - i. Skin?..... Yes No
 - j. Any other part of the body?..... Yes No
- Explain any "Yes" answers in #12.

- 10a. Is there evidence of dementia? Yes No
- 11. If your examination revealed any condition requiring further investigation or immediate treatment, have you advised the Proposed Insured? Yes No

12. Remarks and Explanations _____

To the Medical Examiner: Any erasures or alterations in this report should be initialed by you.

Examination was made at: Proposed Insured's Residence Proposed Insured's Business Examiner's Office Other _____

Examiner's Name (please print) _____

Examiner's Signature _____ Date Signed _____

Examiner's Address _____

Board Certified Board Eligible Phone Number _____ SSN/TIN _____

STATE REQUIRED NOTICES

For Applicants in Arkansas, District of Columbia, Hawaii, Louisiana, Maine, New Mexico, Oklahoma, Pennsylvania, Tennessee, and Virginia:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THESE NOTICES:

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

This page must be given to the Proposed Insured.



- ReliaStar Life Insurance Company
- Security Life of Denver Insurance Company

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Consent to Blood (and Other Body Fluids) Testing Disclosure Authorization

I give my consent to the above named insurer, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

- (1) Blood (and/or other body fluids) test for antibodies to the AIDS virus (HIV); if I reside in a state which permits insurers to conduct this test; and
- (2) Such other or additional tests which the company 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 (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.
- (3) The test(s) for the antibodies to the AIDS virus (HIV) will be conducted following approved test protocols.
- (4) If state law permits, I will be notified of positive HIV test results. Otherwise, I will be asked to designate, in writing, the name and address of the physician to whom I want the test results sent. I understand that in some states positive results may only be disclosed to the physician I designate to receive the results.

I further understand that test results will not be released or disclosed to any party (other than the company 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 requires disclosure; or
- (c) A court order requires disclosure.

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

- (5) I understand that the company may report to the Medical Information Bureau (MIB) any abnormal blood (and/or other body fluids) test, but the company will not disclose the type of blood (and/or other body fluids) test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I know that I have the right to get 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 TESTING AND DISCLOSURE AUTHORIZATION.

 Name of Proposed Insured

 Signature of Proposed Insured

 State of Residence of Proposed Insured

 Date

 Name of Examiner

 Signature of Examiner