Life

APPLICATION PART II - MEDICAL EXAMINATION

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

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

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 ______________________

	Yes	No
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:		
a. Dizziness, fainting, seizures, convulsions, optic neuritis, headache, paralysis, stroke, TIA, mental or nervous disorder, including anxiety or depression?	☐	☐
b. Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☐
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	☐	☐
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	☐	☐
e. Sugar, albumin, blood or pus in urine, sexually transmitted disease, nephritis, stone, or other disorder of kidney, bladder, breasts, prostate, or reproductive organs?	☐	☐
f. Diabetes, thyroid, or other endocrine disorder?	☐	☐
g. Disorder of the skin or lymph glands, arthritis, or disorder of the muscles, joints or bones?	☐	☐
h. Anemia or other disorder of the blood?	☐	☐
i. Positive HIV (Human Immunodeficiency Virus) test, AIDS (Acquired Immunodeficiency Syndrome), or other disease or disorder of the immune system?	☐	☐
2. Have you:		
a. Experienced any symptom(s) for which you have not yet consulted a health care provider?	☐	☐
b. Had any operation(s) in the past 10 years?	☐	☐
c. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests not yet performed?	☐	☐
d. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years?	☐	☐
e. Sought or been advised to seek advice or treatment for the use of alcohol? *(If "Yes", complete Alcohol Usage Questionnaire.)*	☐	☐
f. In the past 10 years been confined for observation, care, or treatment in a hospital or other health care facility?	☐	☐
g. In the past 5 years consulted any health care provider(s), not already identified, for any reason including routine physical examination?	☐	☐
h. Ever had a tumor, pre-cancerous lesion or cancer?	☐	☐
3. Are you:		
a. Presently taking any medication(s), including non-prescription/over the counter medication or supplements?	☐	☐
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.)*	☐	☐

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. Any person who, with the 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 may have violated the state law.

Signed at (City, State) ______________________________ Date ________

X Signature of the Proposed Insured (if age 15 or older) ______________________________ Date ________

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

X 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

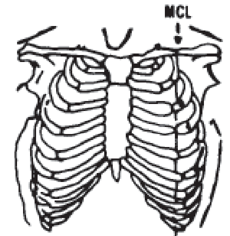
If "Yes", diagnosis: ☐ Functional ☐ Organic

Type ____

Please indicate:

Timing	Intensity	Quality
☐ Systolic	☐ Faint	☐ Soft
☐ Presystolic	☐ Moderate	☐ Blowing
☐ Diastolic	☐ Loud	☐ 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

b. Is there any evidence the Proposed Insured is unable to perfom independent activities of daily living? (IADL) .... ☐ 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 ____________

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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