

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:
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 (excluding prior HIV testing information)?
2. In the past 10 years, have you ever been treated for or been diagnosed by a licensed medical doctor for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), systemic lupus erythematosus, rheumatoid arthritis, scleroderma, or mixed connective tissue disorder?
3. 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 (excluding prior HIV testing information)?
d. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years (excluding prior HIV testing information)?
e. Sought or been advised to seek advice or treatment for the use of alcohol?
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 (excluding prior HIV testing information)?
h. Ever had a tumor, pre-cancerous lesion or cancer?
4. 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?

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				

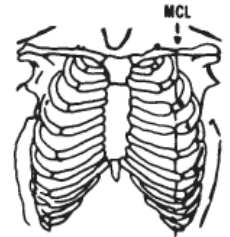
- b. Rate of Pulse _____
- 4a. Have the blood and urine specimens been sent?.. Yes No
- b. Lab ticket number _____
- c. Name of Lab _____
- 5. Was the EKG completed? (if required)..... Yes No
- 6. For females only.
 - a. Was the Proposed Insured menstruating at the time the urine specimen was voided? 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 _____



Insurer Name _____

Insurer Address _____

VERMONT - HIV TESTING INFORMATION STATEMENT & CONSENT FORM

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont Aids Hotline for information about free testing, the number is listed below) and any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the informed consent form any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;
2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to retest once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that retest.

3. If you are denied insurance because of a positive test result, you may request a retest once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such retest is negative, an insurer may not deny coverage based upon the initial test results.

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV antibodies.

Informed Consent

To be signed at the time when medical professional or company agent obtains sample.

This statement has been read aloud to me and I understand this ***HIV TESTING INFORMATION STATEMENT & CONSENT FORM***. I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

_____ <i>Name of Proposed Insured</i>	_____ <i>Signature of Proposed Insured</i>	_____ <i>Date</i>
_____ <i>Birthdate</i>	_____ <i>State of Residence</i>	
_____ <i>Name of Medical Professional or Company Agent Collecting Sample</i>	_____ <i>Signature of Medical Professional or Company Agent</i>	

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO: :

Name

Address

City

State

Zip Code