MAIL TO:

☐ **Investors Life Insurance Company of North America**
Administrative Office: P.O. Box 149138 • Austin, TX 78714-9138

Part II–Medical Applications For Insurance

STATEMENTS BY THE APPLICANT MADE TO AND RECORDED BY MEDICAL EXAMINER

Proposed Insured ________ ________ ________ Birth Date ________ ________ ________
First name Middle initial Last name Month Day Year

1. a. Name and address of your personal physician? (If none, so state) ________
   b. Date and reason last consulted? ________
   c. What treatment was given or medication prescribed? ________

2. During the past ten years have you:	Yes	No
a. Had any disorder of eyes, ears, nose or throat?	☐	☐
b. Had dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c. Had a lung or chronic respiratory disorder, asthma, emphysema, pneumonia, shortness of breath, persistent hoarseness or cough, or tuberculosis?	☐	☐
d. Had chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Had intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Had sugar, albumin, blood or pus in urine; diabetes, thyroid, or other endocrine disorder; stone or other disorder of kidney, bladder, prostate, or reproductive organs?	☐	☐
g. Had arthritis, gout, neuritis, sciatica, or rheumatism; loss of limb or deformity; other disorder of the muscles or bones, spine, back, or joints; or skin disorder?	☐	☐
h. Had cancer, tumor, cyst, or leukemia; any lymph-gland, anemia, or blood abnormalities?	☐	☐
i. Been diagnosed or treated by a physician/doctor or member of the medical profession for AIDS/ARC; night sweats; unexplained fever or weight loss; lumps in neck, armpit or groin; discolored areas or lesions of the skin or mouth; persistent cough; persistent diarrhea; or a sexually transmitted disease?	☐	☐
j. Tested positive for the presence of the AIDS virus or antibodies to such virus? (Answer "yes" only if the test was an FDA-licensed blood test. You may answer "no" if the positive test result was received at an anonymous counseling and testing site).	☐	☐
k. Received advice or medical treatment for or been convicted for the use of alcohol or drugs or attended Alcoholics Anonymous?	☐	☐
3. Are you now under observation, taking treatment or taking medications prescribed by a physician?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. During the past 5 years have you:		
a. Had any mental or physical disorder not listed above?	☐	☐
b. Had a checkup, consultation, illness, injury, surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
d. Had electrocardiogram, X-ray or operation?	☐	☐
e. Had any diagnostic test, hospitalization, or surgery scheduled which has not yet been completed?	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐

DETAILS of "Yes" answers. **IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.** Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.

8. Family History: diabetes, cancer, high blood pressure, heart or kidney disease? Yes ☐ No ☐

	Age if Living?	Cause of Death	Age at Death?
Father			
Mother			
Brothers and Sisters No. Living . . . . . No. Dead.			

The statements and answers in Part 2 of this application are complete and true to the best of my knowledge and belief. They are to be considered as the basis of any insurance written hereon.

Signed at ________ CITY AND STATE on ________ MONTH ________ DAY 20 ________ YEAR

Witness ________ SIGNATURE OF MEDICAL EXAMINER ________ SIGNATURE OF PROPOSED INSURED

LI-7056 (11-98)

Fees for examinations are paid only through the Administrative Office. This voucher Stub should be completed at the time of the examination and mailed by the examiner to:

Investors Life Insurance Company of North America
Administrative Office: P.O. Box 149138, Austin, TX 78714-9138
(800) 925-6000

EXAMINER'S STATEMENT TO COMPANY
Name of Proposed Insured: (Print) ________
Date of Birth: ________ Date of Examination ________
Name of Agent: (Print) ________
Name of Examiner: (Print) ________
Address of Examiner: ________
Telephone No. of Examiner ________

MEDICAL EXAMINER'S REPORT

10. a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic } 4th Phase			
Diastolic } 5th Phase			

12. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below – if more than one, describe separately)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by ◯
Transmission by ➡

MCL

For comments and your impression?

14. Is there on examination any abnormality of the following:
(Circle applicable items and give details)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (if vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. a. Are there any hernias? ☐ Yes ☐ No b. Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

Details of "Yes" answers. (Identify them.)

Complete for all proposed insureds:

	Yes	No
17. Has proposed insured ever used tobacco in any form?	☐	☐
18. Does proposed insured now use tobacco in any form?	☐	☐
19. Has proposed insured used tobacco in any form within:	☐	☐
a. the past 12 months?	☐	☐
b. the past 36 months?	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to laboratory? ☐ Yes ☐ No

Send Specimen To Laboratory If: there is any history or examination findings indicative of genito-urinary or circulatory impairment (glycosuria, albuminuria, blood pressure over 146 or 90).

I certify that I have carefully examined ______________________ of ______________________
(City and Street Address)

In private, at { my office / his place of business / his home } this ________ day of ______________, 20 ____ at ________ A.M. / P.M.

Signature of Examiner ______________________ Address ______________________

____
(Please Print)

LI-7056 (11-98)

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. This examination report, once begun, becomes the property of the Company and must not be destroyed or suppressed even if the applicant or any one else offers to pay the examination fee in order to avoid having the report sent to the Company.
2. Initial any corrections or alterations you make in the report, do not erase.
3. Give a few details and a diagnostic evaluation of any abnormality noted in the applicant's medical history and examination.

❒ **Family Life Insurance Company**
❒ **Investors Life Insurance Company of North America**

P.O. Box 149138 • Austin, TX 78714-9138 • 1-800-925-6000 • www.familylifeins.com • www.investorslife.com

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions will be based on the test result.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as required or allowed by law.

MEANING OF POSITIVE TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at increased risk of developing AIDS or AIDS-related conditions. The tests are tests for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

NOTIFICATION OF TEST RESULTS

A positive test result will be disclosed to a physician you designate. Because a trained person should deliver that informmation so that you can understand clearly what the test results mean, please list your private physician so that we can have him or her tell you the test results and explain their meaning.

I request that if the HIV antibody test result is positive, you report it to this physician:

Name: ______________________________

Address: ______________________________

City: ______________________ State: __________ ZIP: __________

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. 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.

The results of these tests will be released to the physician you designate. The Department of Public Health will only be notified when mandated by state regulations.

Signature of
Proposed Insured
or Parent/Guardian ______________________________ Date: ______________