

Medical Examination Report - Part 3

Jackson National Life Insurance Company



Home Office: Lansing, Michigan
www.jnl.com

PLEASE PRINT. USE DARK INK.

Proposed Insured's Name (first, middle initial, last name)	SSN (include dashes)	Date of Birth (mm/dd/yyyy)
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1. Have you ever been treated for, or ever had any indication of:
 - a. Disorder of eyes, ears, nose, mouth or throat? Yes No
 - b. Recurrent dizziness, fainting, convulsions or seizures, recurrent headaches, speech defect, paralysis or stroke, mental or nervous disorder, depression or episode of attempted suicide? Yes No
 - c. Persistent shortness of breath, cough, blood spitting; bronchitis, bronchiectasis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? Yes No
 - d. Chest pain, discomfort or tightness; palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? Yes No
 - e. Jaundice, intestinal bleeding; ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, recurrent diarrhea, or other disorder of the stomach, intestines, liver, gall bladder or pancreas? Yes No
 - f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? Yes No
 - g. Diabetes; thyroid or other glandular or endocrine disorders? Yes No
 - h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, spine, back or joints? Yes No
 - i. Deformity, lameness or amputation? Yes No
 - j. Disorder of skin, lymph glands, cyst, tumor, or cancer? Yes No
 - k. Allergies; anemia or other disorder of the blood? Yes No
 - l. Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or chronic infections? Yes No
2. Have you, in the past 10 years:
 - a. Consulted with or been treated by a physician or other medical/health practitioner? Yes No
 - b. Had surgery of any kind? Yes No
 - c. Been a patient in a hospital, clinic, or medical facility? Yes No
 - d. Had an electrocardiogram, X-ray or other diagnostic test? Yes No
 - e. Been advised to have an examination, consultation, or other diagnostic test, hospitalization, or surgery which was not completed? Yes No
3. Are you presently taking any prescribed medication? Yes No
4. Have you had any medication prescribed or recommended? Yes No
5. Are you presently taking any non-prescribed medication, herbal remedies, or alternative or complimentary medicine? Yes No
6. Have you ever used tobacco in any form? If "Yes," give month and year last used: _____ Yes No
7. Have you lost or gained any weight in the past year? Yes No
If "Yes", indicate amount of gain or loss and how long current weight has been constant _____
8. Have you, in the past five years:
 - a. Used barbiturates, heroin, cocaine, marijuana or any other controlled substance except as prescribed by a physician? Yes No
 - b. Been advised by a member of the medical profession to seek treatment or counseling for alcohol or controlled substance use, or to limit alcohol use? Yes No
 - c. Been counseled or treated for alcohol or controlled substance use? Yes No
 - d. Attended or joined any organization for alcohol or controlled substance abuse? Yes No
9. Have you ever tested positive for the Human Immunodeficiency Virus (HIV), also known as the AIDS (Acquired Immune Deficiency Syndrome) virus? Yes No
10. Has any immediate family member died as a result of, or been diagnosed with, cancer, kidney or heart disease, diabetes or high blood pressure prior to age 70? Yes No
11. If Insured is under age 1, was the Insured's birth abnormal or premature? Yes No
If "Yes," weight at birth: ___ lbs. ___ oz. Number of months premature: _____
12. If Insured is female, have you had:
 - a. Any disorder of breasts, uterus or ovaries? Yes No
 - b. Any medical problems during pregnancy? Yes No
 - c. Are you pregnant now? Anticipated date of delivery: _____ Yes No



Medical Examination Report - Part 3 (Continued)

Personal Physician's Name *If none, check here:* Phone No. (include area code) _____

Personal Physician's Address _____ Date Last Seen (mm/dd/yyyy) _____

Reason for last visit and results _____

Details of "Yes" answers. (If more space is needed, please attach an additional page with signature and date signed.)

No.	Dates/Duration	Diagnosis/Treatment/Result	Attending Physician's/Medical Facility's Name and Address

READ CAREFULLY BEFORE SIGNING

- I represent to the best of my knowledge and belief that my answers and statements above are true, complete, and correctly recorded.
- I understand that this Medical Examination Report - Part 3 (the "Report") shall be part of the Application including but not limited to examination reports, questionnaires, supplements, and amendments, and that my statements and answers on this Report (and on the Application) must continue to be true and complete as of the date coverage becomes effective. I understand that if any of my answers and/or statements on this Report or the Application change prior to coverage becoming effective, I must inform the Company in writing; and no coverage will be in effect until the Company determines whether to provide coverage, and on what terms.

Signature of Proposed Insured (or informant) _____ Date Signed (mm/dd/yyyy) _____

Measured Height (without shoes) in.	Measured Weight (clothed) lbs.	Pulse (at rest)	Blood Pressure		
			At Rest	After 10 min.	Repeat if > 138/85

I performed this examination at the above time and date and witnessed the proposed insured's signature. I am am not related to the applicant or producer/representative (agent).

Medical Examiner's Name _____ Signature _____

Address _____

