JACKSON NATIONAL LIFE INSURANCE COMPANY, 5901 Executive Dr., Lansing, MI 48911
Medical Examination Report - Part 3

SEX: ☐ Male ☐ Female

Examination of:
(Print Full Name) ____ DOB ______________
First Middle Initial Last

1. Name and address of personal physician. If none, check box ☐

Name ____________________

Street No. or RFD ____________________

City, State & ZIP Code ____________________

Date and reason last consulted:

2. Have you ever been treated for, or ever had any indication of:	Yes	No
a. Disorder of eyes, ears, nose, mouth or throat?	☐	☐
b. Recurrent dizziness, fainting, convulsions or seizures, recurrent headaches, speech defect, paralysis or stroke, mental or nervous disorder, depression or episode of attempted suicide?	☐	☐
c. Persistent shortness of breath, cough, blood spitting; bronchitis, bronchiectasis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
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?	☐	☐
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?	☐	☐
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other glandular or endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	☐	☐
k. Allergies; anemia or other disorder of the blood?	☐	☐
l. Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or chronic infections?	☐	☐
3. Have you, in the past five years:		
a. Consulted or been treated by a physician or other medical practitioner?	☐	☐
b. Been a patient in a hospital, clinic, or medical facility?	☐	☐
c. Had an electrocardiogram, X-ray or other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
4. Are you presently taking any prescribed medication?	☐	☐
5. Have you ever had military service deferment, rejection, or discharge because of a physical or mental condition?	☐	☐
6. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐

7. Have you, in the past five years:	Yes	No
a. Used barbiturates, heroin, cocaine, marijuana or any other illegal, restricted or controlled substance except as prescribed by a physician?	☐	☐
b. Been advised by a member of the medical profession to seek treatment or counseling for alcohol or drug problems or to limit alcohol use?	☐	☐
c. Been counseled for alcohol or drug use?	☐	☐
d. Been treated for alcohol or drug use?	☐	☐
e. Attended or joined any organization for alcohol or drug related problems?	☐	☐
8. a. Have you smoked cigarettes in the past 12 months?	☐	☐
b. If "No," do you use tobacco in any other form?	☐	☐
9. Have you lost or gained any weight in the past year? If yes, indicate amount of gain or loss and how long current weight has been constant.	☐	☐
10. Has a member of the medical profession ever diagnosed you as having, or treated you for: a. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
11. If Insured Under Age 1: Was the Insured's birth abnormal or premature? If "Yes," weight at birth _______lbs. _______ oz. Number of months premature_______	☐	☐
12. Have you had:		
a. Any disorder of breasts, uterus, ovaries?	☐	☐
b. Any medical problems during pregnancy?	☐	☐
c. Are you pregnant now? Anticipated date of delivery ______________	☐	☐
13. Has any member of your immediate family been diagnosed as having: a. Diabetes, cancer, high blood pressure, heart disease, kidney disease, mental illness or any hereditary disease?	☐	☐

b.	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers & Sisters			

Details of "Yes" answers. Include: a. Question Number, b. Diagnosis and treatment, c. Results, d. Dates & durations, e. Names & addresses of all attending physicians and medical facilities.

READ CAREFULLY BEFORE SIGNING

(1) I declare that my answers and statements are correctly recorded, complete and true to the best of my knowledge and belief.

(2) I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give any such information to Jackson National Life Insurance Company. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of 30 months.

(3) I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if any of my answers or statements change prior to delivery of the policy, I must so inform the Company in writing.

Date______________________________ ______________________________
Signature of Proposed Insured (or informant)

____
Witness

Form No. X0576A Rev. 9/90

Medical Examination Report - Part 3

Name of Agent: ______________________

Address: ______________________

14.a. Height (Without shoes) ft. in.	14.b. Weight (Clothed) lbs.	14.c. (Males only) Chest (Full Inspiration) in.	Chest (Forced) Expiration) in.	Abdomen, At Umbilicus in.

Details of "Yes" answers (identify item).

14.d. Did you weigh? ☐ Yes ☐ No 14.e. Did you measure? ☐ Yes ☐ No

15. Blood Pressure - Record 1st Reading. If reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd Readings at 5 min. intervals.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic - 5th phase			

16. 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)

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

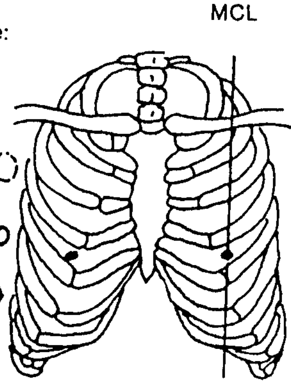
Indicate:

Apex by X

Murmur area by ◌

Point of greatest intensity by O

Transmission by O



For comments and your impression:

17. Pulse:	At Rest	After Exercise	Minutes Later
Rate			
Irregularities per min. (indicate 0, if none)			

18. 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)?	☐	☐
i. Are there any hemorrhoids?	☐	☐

19. Are you aware of additional medical history? ☐ ☐
(A confidential report may be sent to the Medical Department.)

20. Urinalysis:

	Yes	No
a. Is protein present?	☐	☐
b. Is sugar present?	☐	☐
c. Is a specimen being sent to the Home Office?	☐	☐

Details of "Yes" answers (identify item).

Send Specimen (with completed identification slip) to Home Office Reference Laboratory if any of the following are present:
(1) urine tested is abnormal, or
(2) any genitourinary, cardiovascular or diabetic disorder is or has been present, or
(3) if medical history warrants, if a dipstick is unavailable or if the amount of insurance being applied for is more than $300,000.

IMPORTANT: This report is the property of the Insurer and must be mailed immediately to the Company. It should not be given to any other person.

I made the examination reported above and witnessed the Proposed Insured's signature at __________ a.m. __________ p.m. on this __________ day of __________ 19 ______ at (give address) __________

Are you related to the Applicant or Agent? ☐ Yes ☐ No

X ______________________ M.D./D.O.
Medical Examiner (Signature)

____
Name of Medical Examiner (Print or Stamp)

P.O. Box 24068
Lansing, Michigan 48909-4068
800/USE-JNLI (800/873-5654)

Jackson National Life Insurance Company

Notice and Consent Form for AIDS Virus (HIV) Testing

Please Print Applicant's Name (first, middle initial, and last name)	DOB (MM/DD/YYYY) / /	Social Security Number
(Check one box only.) ☐ New Application ☐ Existing Policy	JNL® Reference/Policy Number	

To evaluate your eligibility for insurance, 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 these test results. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

There are several laboratory tests for HIV. The most common is the antibody test, which is a blood test that detects antibodies produced by the body in response to infection with HIV.

A positive antibody test consists of a repeatedly reactive (the same specimen testing positive twice) enzyme immunoassay (EIA) and a reactive Western blot (supplementary test). A positive antibody test means that an individual is infected with HIV; however, this does not always mean that the individual has AIDS. Research indicates that early and regular medical care is important to the health of a person with HIV. Certain treatments are now available to delay HIV-associated illnesses.

A negative antibody test indicates that no detectable antibodies are present in the blood. An individual may not have antibodies because the individual is not infected with HIV or because detectable antibodies have not yet been made in response to infection. The production of these antibodies could take three months or longer. Therefore, in certain cases, an individual may be infected with HIV and yet test negative. Individuals with a history of HIV risk behaviors within the past three to six months should consider retesting.

Like any test, HIV testing is not 100% reliable and may occasionally produce both false positive and false negative results.

Positive HIV test results will adversely affect your application for insurance. This means that your application may be declined.

Positive HIV test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV positive should be considered infected with the AIDS virus and capable of infecting others. The test for HIV antibodies is very sensitive; errors are rare, but they do occur. You should consult your private physician, a public health clinic or an AIDS information organization to provide you with further information on the medical implications of a positive test result.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Company will contact you or the physician you designate below.

All test results will be treated confidentially. They will be reported by the testing laboratory to the Company for the Company's use in underwriting your application for insurance. The Company may disclose test results to the Medical Information Bureau (MIB, Inc.) and, for business use in connection with your application for insurance, to its reinsurers, but in both cases, reported test results will use a non-specified test code which does not indicate that you were tested for the HIV virus. There will be no other disclosure of test results or even that the tests have been done except as allowed or required by law or as authorized by you.

Acknowledgement & Consent:

I hereby acknowledge receipt of an informational brochure regarding HIV**, and the list of AIDS Counseling Services** on the reverse side of this form.

I voluntarily consent to the testing for HIV antibodies and the disclosure of test results as described above. I understand that I have the right to receive a copy of this form, that a photocopy will be as valid as the original, and that this authorization will be valid for a period of 90 days from the date below.

I authorize the disclosure of positive test results to the physician designated below:

Name of Physician	
Address	
City	
State	ZIP

Signature of Proposed Insured or Parent/Guardian
Date

WHITE COPY – Return to Home Office YELLOW COPY – Leave With Client