

**PART II**

**Application for Life Insurance to The Lafayette Life Insurance Company  
MEDICAL HISTORY QUESTIONNAIRE**

**Use BLACK Ink**

<p>1. Print full name of Person being examined _____ Age _____</p>	<p>Amount of insurance applied for: _____</p>																													
<p>2. When were you last examined for insurance and for what company? _____</p>	<p>4. a. FAMILY HISTORY</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">LIVING</th> <th colspan="2">DEAD</th> </tr> <tr> <th>Age</th> <th>State of Health</th> <th>Age</th> <th>Cause of Death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sisters</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		LIVING		DEAD		Age	State of Health	Age	Cause of Death	Father					Mother					Brothers					Sisters				
	LIVING		DEAD																											
	Age	State of Health	Age	Cause of Death																										
Father																														
Mother																														
Brothers																														
Sisters																														
<p>3. a. Name and address of your personal physician? If none, give location of Medical Records. _____</p> <p>b. Date and reason last consulted? _____</p> <p>c. What treatment was given or medication prescribed? _____</p> <p>d. How much time have you lost from work during the last two years because of illness or injuries? <input type="checkbox"/> none _____ weeks</p>	<p>b. Did either parent, brother or sister ever have heart disease, diabetes, stroke or high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give details. _____</p>																													
<p><b>ANSWER ALL QUESTIONS IN THIS COLUMN</b></p> <p>5. HAVE YOU EVER:</p> <p>a. received disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. had high blood pressure or treatment thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. had pain or other discomfort in the chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. had kidney stones, sugar, albumin or blood in the urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. used barbiturates, narcotics, or other drugs, excitants or hallucinogens except as medication prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. been treated for drug habit or alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. smoked cigarettes within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:</p> <p>a. heart murmur, palpitation, abnormal pulse or any other heart or circulatory trouble including varicose veins? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. nervous or mental trouble, convulsions, epilepsy, paralysis, dizzy or fainting spells, or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. asthma, bronchitis, emphysema, shortness of breath, pleurisy, tuberculosis or any other disorder of lungs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. ulcers or any disorder of stomach, liver, gallbladder, pancreas, intestines, appendix, or rectum including hemorrhoids and hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. disorder of the kidneys, bladder, prostate or genitourinary organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. cancer, tumor, cyst, syphilis, goiter or diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. gout, disorder of bone, joint, back, spine, arthritis, rheumatism or any deformity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. allergy or any disorder of the spleen or lymph glands? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. disorder of the skin, eyes, ears, nose, sinuses, throat or larynx? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. disorder of breasts or pelvic organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. disorder of the immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. HAVE YOU WITHIN THE PAST 5 YEARS, OTHER THAN AS NOTED ABOVE:</p> <p>a. had a checkup, consultation, illness, injury, surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. been a patient in a hospital, clinic or other medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. had an electrocardiogram, x-ray, blood study, or other diagnostic tests? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. been advised to have any diagnostic test, hospitalization or surgery which was not completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. HAVE YOU RECEIVED TREATMENT BY A HEALTH CARE PROVIDER OR TAKEN MEDICATION IN THE PAST 2 YEARS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9. DO YOU PARTICIPATE IN REGULAR PHYSICAL EXERCISE? If "Yes," describe type and frequency. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. HAS YOUR WEIGHT CHANGED MORE THAN 10 POUNDS IN THE PAST YEAR? If "Yes," indicate the gain or loss &amp; why. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. In the past ten years have you:</p> <p>(1) had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC"), or AIDS related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(2) received advice or treatment in connection with any of the categories mentioned in (1) above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																													
<p>DETAILS OF "Yes" answers. IDENTIFY QUESTION NUMBER (Include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.)</p>																														

I agree that the above questions and answers in this Medical History Questionnaire shall be considered as Part II of the application for life insurance on my life.

I have carefully read all the above questions, statements and answers and all such statements and answers are correctly recorded and are true as set down above to the best of my knowledge and may be relied upon by The Lafayette Life Insurance Company.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ yr \_\_\_\_\_  
(city) (state)

WITNESS: \_\_\_\_\_  
Signature of Medical Examiner & Degree

\_\_\_\_\_  
Signature of Person Being Examined

### Part III - MEDICAL FINDINGS TO BE FILLED OUT IN PRIVATE

Make a very careful examination of heart and lungs against bare skin.

1 a.		MALES ONLY:				Details of "Yes" answer. (Identify them.)
Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus Relaxed		
ft.    in.	lbs.	in.	in.	in.		
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No						
c. Weight change in past year? _____ lbs. <input type="checkbox"/> Gain <input type="checkbox"/> Loss - Cause?						
2. Blood Pressure: (Repeat if over 142/90)						
(Record all readings)		1st Reading	2nd	3rd		
Systolic						
Diastolic						
(Phase 5)						
3. Pulse:						
(Record all readings)		At Rest	exercise test (25 hops)	3 Minutes Later		
Rate						
Irregularities Per Min.						
4. Heart: Is there any:						
(a) Enlargement		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral? _____		
(b) Murmur(s)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aortic? _____		
(c) Dyspnea		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pulmonic? _____		
(d) Edema		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Septal? _____		
(describe below - if more than one, describe separately)						
Constant		<input type="checkbox"/>	Indicate:			
Inconstant		<input type="checkbox"/>	Apex by			
Transmitted		<input type="checkbox"/>	Murmur area by			
Localized		<input type="checkbox"/>	Point of greatest			
Systolic		<input type="checkbox"/>	intensity by			
Presystolic		<input type="checkbox"/>	Transmission by			
Diastolic		<input type="checkbox"/>				
Soft (Gr. 1-2)		<input type="checkbox"/>	For comments and your impression? →			
Mod. (Gr. 3-4)		<input type="checkbox"/>				
Loud (Gr. 5-6)		<input type="checkbox"/>				
After exercise:						
Absent		<input type="checkbox"/>	Decreased	<input type="checkbox"/>		
Increased		<input type="checkbox"/>	Unchanged	<input type="checkbox"/>		
What is your interpretation? _____						
5. Is there on examination any abnormality of the following:						
(Check applicable items and give details.)						
					Yes	No
(a) eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)					<input type="checkbox"/>	<input type="checkbox"/>
(b) skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ..					<input type="checkbox"/>	<input type="checkbox"/>
(c) nervous system (include reflexes, gait, paralysis)?					<input type="checkbox"/>	<input type="checkbox"/>
(d) respiratory system?					<input type="checkbox"/>	<input type="checkbox"/>
(e) abdomen (included scars)?					<input type="checkbox"/>	<input type="checkbox"/>
(f) genitourinary system (include prostate)?					<input type="checkbox"/>	<input type="checkbox"/>
(g) endocrine system (include thyroid and breasts)?					<input type="checkbox"/>	<input type="checkbox"/>
(h) musculoskeletal system (include spine, joints, amputations, deformities)?					<input type="checkbox"/>	<input type="checkbox"/>
6. Are there any hernias or any hemorrhoids? .....					<input type="checkbox"/>	<input type="checkbox"/>
7. Are you aware of additional medical history? .....					<input type="checkbox"/>	<input type="checkbox"/>
8. Is appearance unhealthy or older than started age? .....					<input type="checkbox"/>	<input type="checkbox"/>
9. Urinalysis:		SPECIFIC GRAVITY	ALBUMIN	SUGAR		
Is specimen being sent to the Lab?		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Is blood being sent to the Lab?		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Lab One P.O. BOX 2035 SHAWNEE MISSION, KS 66201						

I certify I have carefully examined \_\_\_\_\_ and that

the examination was made  my office

in private at  residence of person being examined

place of business of person being examined

Are you acquainted with person being examined?    Yes  No

Date \_\_\_\_\_

Authorized by (AGENT) \_\_\_\_\_

(Medical Examiner & Degree) (Please Print) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Paramedical Affiliation \_\_\_\_\_

This Examination Report must be mailed directly to: The Lafayette Life Ins. Co., 1805 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903

FOR H. O. ONLY

Approved \_\_\_\_\_

Unapproved \_\_\_\_\_



## INFORMED CONSENT FOR HIV ANTIBODY TESTING

### HIV ANTIBODY TEST:

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a specimen for testing and analysis.

One of the tests\* to be performed on this sample, to determine your insurability, may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. This test is not a test for AIDS (Acquired Immunodeficiency Syndrome); AIDS can only be diagnosed by medical evaluation. The testing will only be performed by a certified laboratory and according to the following medical protocol:

1. An initial ELISA test will be done.
  - (a) If the initial ELISA test is negative, a negative finding will be reported by a certified laboratory to the Company.
2. If the initial ELISA test is positive, it will be repeated.
  - (a) If the second ELISA test is also positive, a Western Blot Assay test will be performed.
  - (b) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot Assay test will be performed. If the third ELISA test is negative, a negative result will be reported by a certified laboratory to the Company.
3. Only if at least two ELISA tests and a Western Blot Assay test are all positive will the result be reported as positive. All other results will be reported as negative by a certified laboratory to the Company.

\* For a description of some of the other tests which may be performed and the persons or entities to whom the results of those tests may be disclosed, please refer to the Authorization for Testing of Blood or Other Bodily Fluid and Disclosure of Test Results.

### DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the test will be reported to the Company. The results may be disclosed to employees of the Company who have the responsibility to make underwriting decisions on behalf of the Company or to legal counsel who needs such information to effectively represent the Company with regard to your application. The results may also be reported to the Company's reinsurers (if involved in the underwriting process). If your HIV antibody test is abnormal (positive), only a generic code signifying a non-specific abnormality will be made known to the Medical Information Bureau (M.I.B., Inc.). Negative and indeterminate HIV antibody test results will not be reported to the M.I.B., Inc. The fact that the test has been done and the results of the test will not otherwise be disclosed except as may be required by law or as authorized in writing by you.



**AVAILABLE COUNSELING CENTERS IN THE  
STATE OF CALIFORNIA WHERE ASSISTANCE CAN  
BE OBTAINED TO UNDERSTAND THE MEANING OF  
THE HIV ANTIBODY TEST AND ITS RESULTS**

San Francisco AIDS Foundation  
25 Van Ness Avenue  
Suite 660  
San Francisco, CA 94102  
(415) 864-5855

Sacramento AIDS Foundation  
1900 K Street, Suite 201  
Sacramento, CA 95814  
(916) 448-2437

Central Valley AIDS Team  
P.O. Box 4640  
Fresno, CA 93744  
(209) 264-2436

AIDS Project/Los Angeles  
3670 Wilshire Blvd., Suite 300  
Los Angeles, CA 90010  
(213) 380-2000

AIDS Services Foundation  
of Orange County, CA  
1685-A Babcock Street  
Costa Mesa, CA 92627  
(714) 646-0411

San Diego AIDS Project  
3777 Fourth Avenue  
San Diego, CA 92103  
(619) 543-0300

AIDS Project - Easy Bay  
400 40th Street, Suite 20  
Oakland, CA 94609  
(415) 420-8181

AIDS Project  
595 Millich Drive, Suite 104  
Campbell, CA 95008  
(408) 370-3272

**DELIVER TO PROPOSED INSURED**