

**PART 2**

**CONTINUATION OF APPLICATION to LIBERTY LIFE ASSURANCE COMPANY OF BOSTON  
(Complete for Medical) BOSTON, MASSACHUSETTS**

PROPOSED INSURED'S NAME (FIRST, MIDDLE, LAST) \_\_\_\_\_ DATE OF BIRTH (MONTH, DAY, YEAR) \_\_\_\_\_

1a. 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. Have you ever been treated for or ever had any known indications of: YES NO

- a. Disorder of eyes, ears, nose, or throat?  YES  NO
- b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; (mental or nervous disorder)?  YES  NO
- c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy (with effusion), asthma, emphysema, tuberculosis or other chronic respiratory disorder?  YES  NO
- d. Chest pain, palpitation, high blood pressure, abnormal EKG, elevated cholesterol, 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, or other disorder of the stomach, intestines, liver or gallbladder?  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 endocrine disorders?  YES  NO
- h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the 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

DETAILS of "YES" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, treatment, dates, duration and names and addresses of all attending physicians, medical facilities and patient's or clinic numbers.)

3. Have you been rejected, deferred, or discharged by the armed forces because of physical or mental conditions?  YES  NO

4. Have you had any change in weight in the past year?  YES  NO

5. Other than the above, have you within the past 5 years:
- a. Had any x-rays, electrocardiograms, blood tests, or diagnostic tests?  YES  NO
  - b. Consulted or been attended or examined by any doctor or any other practitioner or been a patient in any hospital, clinic or similar institution?  YES  NO
  - c. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?  YES  NO

6. a. Except as prescribed by a licensed physician, have you ever used narcotics, barbiturates, marijuana or hallucinogenic drugs?  YES  NO
- b. Have you ever received treatment or joined an organization for alcoholism or drug addiction?  YES  NO

7. Family History: diabetes, high blood pressure, heart disease, mental illness, or suicide?  YES  NO

Family Record	Age, if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
No. Living .....			
No. Dead .....			

8a. Have you smoked cigarettes within the past 12 months?  Yes  No

8b. If yes, now many packages per day?

I hereby declare that all of the statements and answers to the above questions are complete and true, to the best of my knowledge and belief, and I agree that the foregoing together with this declaration shall form a part, designated as Part 2, of the application for insurance.

Date \_\_\_\_\_, 20\_\_\_\_ Witness \_\_\_\_\_ M.D. Signature of Person Examined X \_\_\_\_\_

## MEDICAL EXAMINER'S REPORT

9a. Height (in Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Full Expiration)	Abdomen, at Umbilicus	Details of Yes Answers. (Identify them)
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b. Did you weigh?  Yes  No      Did you measure?  Yes  No

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

10. BLOOD PRESSURE: Make two observations at 5 min. intervals. Record all readings.

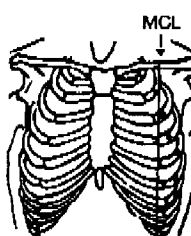
Systolic			
Diastolic 5th phase			

11. Pulse:	At Rest	After Exercise	3 Mins. Later
Rate			
Irregularities per min.			

12. Heart: Is there any:

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

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

Location			Indicate:	
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	X
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	O
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	O
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	↓
Systolic	<input type="checkbox"/>	<input type="checkbox"/>		
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>		
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>		
Soft (Gr 1-2)	<input type="checkbox"/>	<input type="checkbox"/>		
Mod. (Gr 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	Comments and your diagnosis	
Loud (Gr 5-6)	<input type="checkbox"/>	<input type="checkbox"/>		
After Exercise				
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Absent	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		

13. LUNGS: Are the lungs and thoracic cage normal?  Yes  If No, Give Details

14. Is there on examination any abnormality of the following:      Yes      No  
 (Circle applicable areas and give details)

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| (a) Eyes, ears, nose, mouth, pharynx? .....   |                          |                          |                          |                          |
| (b) Skin (incl. scars); Lymph nodes; varicose veins or peripheral arteries? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Nervous system (include reflexes, gait, paralysis)? .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Abdomen (include scars)? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Genitourinary system? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Endocrine system (include thyroid and breasts)? .....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

Urinalysis: Specific Gravity	Albumin	Sugar	A specimen must be sent to Home Office if: a. Amount applied for is \$150,001 or over. b. Subject is 51 years of age or over. c. History of G-U, cardiovascular disease or if current blood pressure is above 140/90. d. History or findings of albumin or sugar. e. Family history of diabetes.
Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No			

I certify that I made this examination at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. on \_\_\_\_\_  
 My office     Individual's office     Individual's home     Other \_\_\_\_\_

Examiner's Signature: \_\_\_\_\_      Examiner's Address \_\_\_\_\_  
 PLH-1005 R3 (8/01)