

MEDICAL QUESTIONS

Full name of person proposed for insurance: _____

Date of Birth (Month/Day/Year): _____

Name, address and telephone number of your personal physician? (If none check box) None _____

Date and reason last consulted? _____

What treatment was given or medication prescribed? _____

MEDICAL QUESTIONS - Each question must be individually asked and answered.

To the best of your knowledge, has any Proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1) Illness, injury or disease of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | 11) Any illness or disease of the male or female reproductive organs, sexually transmitted disease, prostate problems, irregular menstruation or abnormal pap test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Epilepsy, seizures, chronic headaches, head injury, paralysis, or other disorder of the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> | 12) An examination, treatment or consultation with a doctor or health care provider other than above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Anxiety, depression, affective disorder, eating disorder, psychotic disorder, or other psychiatric treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 13) Had or been advised to have a check-up, consultation, lab test, EKG, x-ray, or other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Asthma, emphysema, tuberculosis, shortness of breath, persistent hoarseness or cough, or other respiratory illness or disease? | <input type="checkbox"/> | <input type="checkbox"/> | 14) Received or been advised to have treatment for drug usage, whether legal or illegal, alcoholism or been a member of AA? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) High blood pressure, heart attack, stroke, heart murmur, palpitation, arrhythmia, chest pain, rheumatic fever, or other illness or disease of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> | 15) Are you currently under the observation of a physician or taking medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Ulcer, colitis, Crohn's disease, diverticulitis, hepatitis, intestinal bleeding, or illness or disease of the gallbladder, stomach, intestines, or liver? | <input type="checkbox"/> | <input type="checkbox"/> | 16) Family History: Is there a history of cardiovascular disease or cancer in parent/siblings prior to age 60? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system? | <input type="checkbox"/> | <input type="checkbox"/> | 17) Do you participate in a regular, supervised exercise program or other organized sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Diabetes, thyroid disorder, cholesterol elevation, anemia, or other illness or disease of the blood? | <input type="checkbox"/> | <input type="checkbox"/> | 18) Do you know of any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure, Diabetes, or committed suicide? (Please show age at onset and/or date of death). | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Arthritis, gout, lupus, illness, injury or disease of the back, spine or joints, or other illness, injury or disease of the muscles, bones or skin? | <input type="checkbox"/> | <input type="checkbox"/> | 19) Have you had any weight change in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Cysts, tumor, skin cancer or any other cancer or malignancy? | <input type="checkbox"/> | <input type="checkbox"/> | 20) Have you or any Proposed Insured EVER, had or been told you/they have AIDS, or AIDS Related Complex (ARC), or been tested for HIV antibodies for the purpose of obtaining insurance? | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY

	Age if Living?	Status of Health	Age of Death?	Cause of Death?
Father				
Mother				

Give details regarding "yes" answers number 1-20 (Please print)

Question No.	Disease, symptom, injury, etc.	Dates	Duration	No. of Attacks	Name and Address of Attending Physicians and Hospitals

I represent that I have read and understand all the statements and answers herein and in Part 1 of my application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded whether written in my own hand or not. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. I agree that this application and any policy or policies issued based on this application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgement and ratification of any corrections made in the application; except, that no change in amount of insurance, age at issue, classification, kinds of insurance or benefits will be made unless agreed in writing by the applicant.

AUTHORIZATION: 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 to the Life Investors Insurance Company of America, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

Date _____

Signature of Proposed Insured _____

Examiner _____

Signature of Parent if insured is a minor _____

LIFE INVESTORS INSURANCE COMPANY OF AMERICA

4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

Part 2 — MEDICAL EXAMINER'S REPORT

21. Your patient? Yes No If so, how long?

22. Height (in shoes) Ft. Weight (clothed) In. Lbs.

Males Only

Chest (full inspiration) In.	Chest (forced expiration) In.	Abdomen (at umbilicus) In.
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Did you weigh? Yes No Did you measure? Yes No

23. Blood Pressure (Record all readings.) If initial blood pressure is elevated (140/90 or over), please give repeat readings.

	Initial Reading	After Exercise	3 Minutes Later
Systolic			
Diastolic 5th phase			

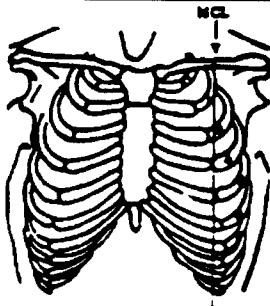
	At Rest	After Exercise	3 Minutes Later
24. Pulse Rate			
Irregularities per min.			

25. Heart Murmur No. 1 No. 2

Is there any:	Yes	No	Location	Murmur		
				No. 1	No. 2	
Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constant	<input type="checkbox"/>	<input type="checkbox"/>	
Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	
Edema	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	
Murmur(s)*	<input type="checkbox"/>	<input type="checkbox"/>	Localized	<input type="checkbox"/>	<input type="checkbox"/>	
*Describe below. If more than one, describe separately.)				Systolic	<input type="checkbox"/>	<input type="checkbox"/>
				Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Soft (Gr. 1-2)				Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
				Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
				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"/>	

Indicate:

- Apex by X
 - Murmur area by ⊙
 - Point of greatest intensity by ○
 - Transmission by →
- For comments and your impression.



26. 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 (include 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)?
27. a. Are there any hernias?
- b. Any hemorrhoids?

(Your confidential report may be sent to the Medical Director)

28. Are you aware of additional medical history?

29. Specific Gravity Albumin Sugar

Please complete the Dipstix. Please send a portion of the specimen to Home Office Reference Laboratory, P.O. Box 2035, Shawnee Mission, Kansas 66201.

Details of "Yes" answers. (Identify item number.)

Examination made at the request of _____, Agent

I certify that I have made this examination of _____

at _____ (Place of Examination) _____ (City) _____ (State) on _____ at _____ A.M./P.M.

and that the foregoing questions have been asked and the answers of the Applicant recorded as stated.

Signature _____ M.D., Medical Examiner