

FEE \$25.00

DO NOT DETACH

EXAMINER'S FEE VOUCHER
LINCOLN BENEFIT LIFE COMPANY
LINCOLN, NEBRASKA

Lincoln Benefit Life Company
P.O. Box 80469
Lincoln, Nebraska 68501
402/475-4061

Examination of _____

Date made _____

By _____ M.D.
Examiner's Name, Please Print

_____ Address

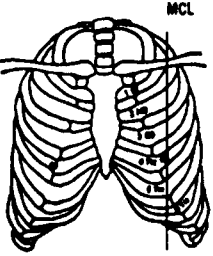
_____ Address

(Payment of this Voucher will be made within 30 days)

Amount of Insurance \$ _____ Name of agent who solicited application _____

PART TWO (MEDICAL EXAMINER'S REPORT)

This examination should be made in private. If a 3rd person is present, give details.

11.	HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	MALES ONLY:			Details of "Yes" answers. (Identify item.)						
			CHEST (FULL INSPIRATION)	CHEST (FORCED EXPIRATION)	ABDOMEN AT UMBILICUS RELAXED							
Did you weigh? <input type="checkbox"/> YES <input type="checkbox"/> NO Weight change in the past year? _____ Lbs. <input type="checkbox"/> Gain <input type="checkbox"/> Loss - Cause? _____												
12. Blood Pressure (Record all readings) All readings to be taken in sitting position. If first reading over 140/90 make two additional observations Systolic <table border="1" style="display: inline-table;"><tr><td> </td><td> </td><td> </td></tr></table> Diastolic <table border="1" style="display: inline-table;"><tr><td> </td><td> </td><td> </td></tr></table>												
13. Pulse: _____ Irregularities Per Min.: _____ ALL EXAMINATIONS MUST HAVE A URINE SPECIMEN SUBMITTED TO: OSBORN LABORATORIES, BOX 2920, SHAWNEE MISSION, KS 66201-9890												
14. Have you submitted a urine specimen to Osborn Laboratories? <input type="checkbox"/> YES <input type="checkbox"/> NO 15. If proposed insured does not smoke cigarettes, DOES he/she use tobacco in any other form? <input type="checkbox"/> YES <input type="checkbox"/> NO												
16. Urinalysis: <table border="1" style="display: inline-table;"><tr><td>SPECIFIC GRAVITY</td><td>ALBUMIN</td><td>SUGAR</td></tr></table>							SPECIFIC GRAVITY	ALBUMIN	SUGAR			
SPECIFIC GRAVITY	ALBUMIN	SUGAR										
17. HEART: (a) Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO (b) Is heart enlarged? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, describe) (c) Is murmur present? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete 17d) (d) Murmur is: <input type="checkbox"/> Constant <input type="checkbox"/> Transmitted <input type="checkbox"/> Presystolic <input type="checkbox"/> Apical <input type="checkbox"/> Soft (Gr.1-2) <input type="checkbox"/> Inconstant <input type="checkbox"/> Localized <input type="checkbox"/> Diastolic <input type="checkbox"/> Basal <input type="checkbox"/> Mod. (Gr.3-4) <input type="checkbox"/> Other <input type="checkbox"/> Loud (Gr.5-6) After exercise: <input type="checkbox"/> Unchanged <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Absent												
Show Location Of: Apex by _____ Area of murmur by _____ Point of greatest intensity by _____ Transmission by _____												
Your impression? _____												
18. Is there on examination any abnormality of the following: (Circle applicable items and give details.) YES NO												
(a) Eyes, ears, nose, mouth, pharynx <input type="checkbox"/> <input type="checkbox"/> (If vision or hearing markedly impaired, indicate degree and correction.)												
(b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins) <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 (including scars) <input type="checkbox"/> <input type="checkbox"/>												
(f) Genitourinary system (including 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"/>												
Have you any pertinent information not brought out above? <input type="checkbox"/> <input type="checkbox"/>												

Examiner's Signature _____ M.D. Examiner's address: _____

Date _____ Examiner's phone number: _____

LINCOLN BENEFIT LIFE
C O M P A N Y

A Member of Allstate Financial Group

P.O. BOX 80469
LINCOLN, NE 68501-0469

Name _____

Policy # _____

Date of Birth _____

Social Security # _____

NOTICE AND CONSENT FORM FOR AIDS-RELATED TESTING

To evaluate your insurability, the insured named above (the Insurer) has requested that you provide a sample of your blood, urine, or oral fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of counseling services is located on the reverse side of this form.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. Antibodies are blood cells produced by the body in response to infection. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application will probably be declined, or an increased premium charged, or other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. If your test result is positive, it may be released to an insurance medical information exchange or another insurer only if a non-specific blood test result code is used which does not indicate that you were subject to testing related to the human immunodeficiency virus.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a positive test result: _____

In the event the result is positive, you will be urged to contact a private physician, County Health Department, State Department of Health Services, local medical societies, or alternative test sites for appropriate counseling. If no physician is named above, the result will be sent to you at the address provided by registered mail with delivery restricted to you only.

Consent

I have read and understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the collection of blood, urine, or oral fluid from me, the testing of blood, urine, or oral fluid, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test is positive. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent Guardian _____

Name of Proposed Insured (PRINT) _____

Date Signed: _____

(This Consent is not valid 6 months after this date!)

Address _____

AIDS COUNSELING ORGANIZATIONS

*The following organizations can assist you in understanding
the meaning of the HIV antibody test and its results,
as well as provide or help you secure counseling:*

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

**AIDS Project
-East Bay**
400 40th Street
Suite 20
Oakland, CA 94609
415/420-8181

**Sacramento
AIDS Foundation**
1900 K Street
Suite 201
Sacramento, CA 95814
916/448-2437

ARIS Project
595 Millich Drive
Suite 104
Campbell, CA 95008
408/370-3272

**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**
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