

**ANSWERS MADE TO THE MEDICAL EXAMINER**

In continuation of and forming a part of application for insurance to

LINCOLN MUTUAL LIFE INSURANCE COMPANY, LINCOLN, NEBRASKA 68501

Part

Proposed Insured

First name Middle initial Last name

Birth Date:

Month Day Year

1. a. 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 had or been treated for:

Yes No

- a. Seizure disorder, fainting, paralysis, nervous or mental disorder, dizziness or any disease or abnormality of your brain or nervous system?
- b. High blood pressure, chest pain, heart attack, rheumatic fever, heart murmur, stroke or any disorder of your heart or blood vessels?
- c. Asthma, emphysema, shortness of breath, chronic cough, pneumonia, or any disorder of your lungs or respiratory system?
- d. Recurrent abdominal pain, indigestion, ulcer, diarrhea, colitis, hepatitis, any bleeding from or disease of your stomach, intestines, gall bladder or liver?
- e. Sugar, protein or blood in your urine, kidney stone or any disorder of your kidneys, bladder, prostate, ovaries, uterus, or complications of pregnancy?
- f. Diabetes, thyroid or other glandular disorder?
- g. Arthritis, neuritis, gout, rheumatism, any disorder of your back, bones or joints?
- h. Disorder of your eyes, ears, nose or throat?
- i. Cyst, tumor, cancer, anemia or blood disorder?
- j. Disorder of your skin, lymph nodes or breasts?
- k. Sexually transmitted disease?
- l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune deficiency disorder?

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

3. Have you used any form of tobacco within the last three years? If yes, state type and amount

4. Has your weight changed in the last three years? If yes, explain

5. During the last five years, have you:

- a. Had a checkup, consultation, illness or surgery?
- b. Been treated at a hospital, clinic or other facility?
- c. Had an electrocardiogram, x-ray or other medical test?
- d. Been advised to take any test or surgery which was not done?
- e. Tested positive for antibodies to the AIDS (HIV)-Human Immunodeficiency Virus?
- f. If answer to #5c is Yes, was the HIV test confirmed by a Western Blot Test?

6. Are you at the present time taking medication or under a doctor's care for any condition?

7. Have you ever used drugs, other than as proscribed, or been treated or advised to be treated for alcohol or drug use?

8. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?

9. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide....

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living .....			
No. Dead .....			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_

LW160 Witness \_\_\_\_\_ M.D.

(Signature of Medical Examiner)

(Signature of Proposed Insured)

**MEDICAL EXAMINER'S REPORT**

Part II

10a.	Height (In Shoes) ft.    in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	Details of "Yes" answers. (Identify item.)
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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

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	4th phase		
	5th phase		

12. Pulse:

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

13. 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)

Location										
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Indicate:							
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by							X
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by							O
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by							O
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by							▶
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"/>								
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>								

For comments and your impression?

After exercise:

Increased      Absent    
 Unchanged      Decreased

14. Is there on examination any abnormality of the following:  
*(Circle applicable items and give details.)*

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? <small>(if vision or hearing markedly impaired, indicate degree and correction)</small>	<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 (include 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"/>

15. (a) Are there any hernias?  Yes  No    (b) Any hemorrhoids?  Yes  No

16. Are you aware of additional medical history?  Yes  No  
(A confidential report may be sent to the Medical Director)

Urinalysis: Specific Gravity	Albumin	Sugar	Send Specimen To Home Office If: 1. 65 years of age or over. 2. \$100,000 of insurance or more. 3. History of diabetes, urinary or kidney impairment.	Name of Company's Agent?
Is specimen being sent to Home Office lab? <input type="checkbox"/> Yes <input type="checkbox"/> No				

I certify that I have carefully examined \_\_\_\_\_  
 in private, at } my office  
his place of business } this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_ at \_\_\_\_\_ A.M.  
his home } \_\_\_\_\_ P.M.  
 Signature of Examiner \_\_\_\_\_ Address \_\_\_\_\_

(Please Print)

**Review report carefully for completeness of all sections then mail directly and without exception to the Medical Director at the Home Office of the Company.**