LUSO-AMERICAN LIFE INSURANCE SOCIETY

Part Two of Application

Every question must be asked by Medical Examiner and the answers recorded in ink in the Examiner's own handwriting.
Please print names and addresses. The Proposed Insured must sign in the Examiner's presence. Examinations must be made in private.

1. Full Name of Proposed Insured	2a. Birthdate	2b. Age

3. For how much insurance are you applying?

4. Family Record	Living: Age	Living: State of Health	Dead: Age at Death	Dead: Cause of Death
Father				
Mother				
Brothers and Sisters No. living___ No. dead___				

5. Have any of your parents, brothers or sisters ever had heart disease, diabetes, or mental illness? Yes No

	Yes	No
6. a. Have you smoked one or more cigarettes within the last 12 months?	☐	☐
b. Have you been a cigarette smoker within the past 10 years?	☐	☐
7. Have you ever received compensation for sickness or injury or been deferred or discharged from military service for physical reasons?	☐	☐
8. In the past 5 years, have you used:		
a. alcoholic beverages to excess or intoxication?	☐	☐
b. barbiturates, sedatives, or tranquilizers habitually?	☐	☐
c. L.S.D., marijuana, cocaine, or any amphetamine?	☐	☐
d. heroin, morphine, or other narcotic drug?	☐	☐
9. In the past 10 years, have you been treated for alcoholism or any drug habit?	☐	☐

Give complete information regarding "Yes" answers to questions 5 thru 17, under "Details" below. Specify conditions, severity, date, duration, frequency of attacks, aftereffects, and name and address of each doctor and of each hospital.

	Yes	No	Details
10. In the past 5 years have you been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?	☐	☐	
11. In the past 5 years, have you had an X-ray, electrocardiogram, blood study or other diagnostic test?	☐	☐	
To the best of your knowledge and belief:			
12. in the past 10 years have you had or been told you had:			
a. dizziness, fainting spells, epilepsy, nervous breakdown, severe headaches, or any disease or disorder of the brain or nervous system?	☐	☐	
b. asthma, hay fever, chronic cough, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system?	☐	☐	
c. high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of heart or circulatory system?	☐	☐	
d. any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver, or gall bladder?	☐	☐	
e. nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy?	☐	☐	
f. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?	☐	☐	
g. anemia, goiter, or any disease or disorder of the blood or glands?	☐	☐	
h. rheumatic fever, diabetes, or sugar, albumin, or blood in the urine?	☐	☐	
i. cancer, or a tumor or ulcer of any kind, or venereal disease?	☐	☐	
j. varicose veins, phlebitis, or a hernia of any kind?	☐	☐	
k. any disease or disorder of the eyes, ears, nose, or throat?	☐	☐	
13. a. have you now any abnormality, deformity, disease, or disorder?	☐	☐	
b. are you receiving treatment or taking medication of any kind?	☐	☐	
14. a. When did a physician or practitioner last examine, advise, or treat you? Name__________ Date______ Address__________	☐	☐	
b. Give reason for consultation.	☐	☐	
15. In the past 5 years, have you consulted or been treated or examined by any physician or practitioner (a) not named above	☐	☐	
(b) for any cause not recorded above?	☐	☐	
16. Have you lost 10 or more pounds during past 12 months? (give amount)	☐	☐	
17. In the past 10 years have you:			
a. had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex (ARC), or AIDS related conditions?	☐	☐	
b. received advice or treatment in connection with any of the categories mentioned in (1) above?	☐	☐	

I hereby agree that the above questions and answers shall form Part Two of my pending application for insurance, and also of any subsequent application by me for insurance in this Company, unless I then undergo another medical examination which by its terms is made a part of such application, and of subsequent applications.

Dated at __________ (City) , __________ (State) **this** ________ **day of** __________ , 20____

Witness __________ M.D.
Medical Examiner

____
Signature of Proposed Insured

Part Three

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

Name of Agent

Make a careful examination of heart and lungs with stethoscope against bare skin. With some histories, findings may have particular significance. Comments regarding relevant findings should be included under "Details" below.

1. Height in shoes ______ ft. ______ in. Did you measure?______
   Weight without coat ________ lbs. Did you weigh? ______

3a. Pulse Seated

3b. Is pulse irregular? If so describe, and where applicable, give the number of irregularities before and after exercise sufficient to increase pulse rate to 100 or more.

2. Measurements - on bared skin
   Chest forced inspiration _______ in. forced expiration ________ in.
   Abdomen _______ in.

4. Blood Pressure. **Please record all readings.** With history of hypertension or if first reading is over 135 systolic or over 85 diastolic, take two additional readings at intervals.
   First Reading Systolic _______ Diastolic _______
   Subsequent Readings __________________ __________________
   Is diastolic at: Disappearance of all Sound (Phase V) ☐ or Change of Sound(Phase IV) ☐

	Yes	No
5. **Do you find any evidence of past or present disease:**		
a. of the heart and blood vessels?	☐	☐
is there a murmur? If "yes", give location, timing,	☐	☐
transmission, quality, intensity, and effect of exercise.	☐	☐
Any hypertrophy? If "yes", give degree.	☐	☐
Any arteriosclerosis? If "yes", describe.	☐	☐
b. of the lungs? Describe and give location.	☐	☐
c. of any of the abdominal organs? Palpate for any areas	☐	☐
tenderness, masses, or enlargement of liver or spleen.	☐	☐
d. of the skin, breasts, ears, middle ears, eyes, throat?	☐	☐
e. of the brain or the nervous system?	☐	☐
Test knee jerks and pupillary reactions.	☐	☐
6. a. Is there any enlargement of thyroid?	☐	☐
b. Is it symmetrical, asymmetrical, nodular, diffuse?	☐	☐
7. Are the lymph nodes enlarged? If "yes", describe.	☐	☐
8. a. Is there a hernia? If "yes", describe.	☐	☐
b. Was it ever strangulated?	☐	☐
9. a. Is there any evidence of varicose veins or ulcers?	☐	☐
b. Do they extend above the knees?	☐	☐
10. Is Proposed Insured lame, maimed, or deformed? Describe.	☐	☐
11. a. Does Proposed Insured appear older than stated? If "Yes", give apparent age.	☐	☐
b. Does appearance indicate good health?	☐	☐
12. Were the circumstances under which you completed examination satisfactory? If "No", give details.	☐	☐
13. Are you in any way related to Proposed Insured or agent? Which one and how related?	☐	☐
14. Are youaware of anything but the health, habits, environment, or mode of life which might unfavorably affect the insurability of Proposed Insured? If "Yes", give details. *(A confidential report may be sent to the Medical Director)*	☐	☐
15. How long and how well have you known Proposed Insured?		

Details

URINALYSIS

Specific gravity? ______________ Reaction? ___________________
Albumin? ___________________ Test used? ___________________
Sugar? _____________________ Test used? ___________________
Are you satisfied Specimen is Proposed Insured's
Have you mailed Specimen to Home Office? ☐ Yes ☐ No
Mail Specimen if over 60, if there is history or finding of Albumin or sugar or of any genito-urinary or cardiovascular disease or disorder, or if the amount of insurance applied for (including any term rider) is $200,000 or more.

I have carefully examined ________________________________ this _______ day of _________ 20___, at _____ o'clock ☐ **A.M.** ☐ **P.M.**

Examination was made in private at ☐ my office ☐ residence of Proposed Insured ☐ place of business of Proposed Insured

Examined at ____

After signing, print, type or rubber stamp name and office address below
Name
Street and Number
City, Stattle and Zip Copy

N.B. - THIS EXAMINATION MUST BEAR DATE OF DAY WHEN ACTUALLY MADE AND UNDER NO CIRCUMSTANCES ANY OTHER.

If not a regular appointed Examiner of the Company, state where graduated ________________________ Date of graduation ______
Names of companies for which you examine? ____

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LUSO - AMERICAN LIFE INSURANCE SOCIETY

Consent to Blood (and other Body Fluids) Disclosure Authorization

I give my consent to **Luso-American Life Insurance Society**, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

(1) Blood (and/or other body fluids) test for antibodies to the AIDS virus (HIV); if I reside in a state which permits insurers to conduct this test; and
(2) Such other or additional tests which the insurance carrier may lawfully order.

My consent to this testing is freely given, based on the following understandings:

(1) The purpose of the test(s) is to determine whether I am insurable for life insurance.
(2) I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the insurance carrier for the life insurance will be declined.
(3) The test(s) for the antibodies to the AIDS virus (HIV) will be conducted following approved test protocols.
(4) I will be notified of positive results if the law permits. If such is the case, I will receive a written notice advising me of my right to furnish the insurance carrier with written designation of the physician to whom I want the results sent. I understand that some states permit test results to be disclosed only to physician I designate to receive the test results.

I further understand that the results will not be released or disclosed to any party (other than the insurance carrier and related parties identified above, to whom I hereby authorized disclosure) unless:

(a) I expressly authorize their release in writing; or
(b) A public health reporting law requires disclosure; or
(c) A court order requires disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

(5) I understand that the insurance carrier may report to the Medical Information Bureau (MIB) any abnormal blood test, but the insurance carrier will not disclose the type of blood test which was abnormal.

I know that I have a right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured

Signature of Proposed Insured

State of Residence of Proposed Insured

State of Examiner

Date

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