

Life/DI²

Application Part 2 (A50ME)

Maine Version

This application package may be used for:

- *Adults and Juveniles*

THIS PACKAGE INCLUDES:

- Part 2 of Application (A50ME702)
- Paramedical and examination for Insurance (A59GE803)

GENERAL INSTRUCTIONS

- Use on a non-medical basis, when a non-medical is required and the Part 1 application does not include a non-medical section.
For a non-medical complete:
- Questions 1-14 and signature block
- Supplement "A" and signature block (if applicable)
- When scheduling an exam, furnish the examiner with the name of the soliciting producer, agency name and number, and the total amount of insurance applied for so this information may be included on required forms.
- If an examiner has not previously been authorized by the Home Office, authorization must be obtained from the Med-Fee section of Life New Business before the exam is performed.

INSTRUCTIONS FOR EXAMINERS:

1. Answer all questions completely-
 - Ensure that all required questions are answered. Don't skip any "yes / no" questions.
 - Fully describe all medical history and findings.
 - A history should be described so that the "who, what, when, and why" are clear to the reader. Use Supplement "A" as needed.
 - When the Proposed Insured is unclear as to the specifics, try to include as much information as possible, particularly as to the relevant dates, names, and addresses of physicians, hospitals, etc.
 - In "Details of Yes Answers", reference to the "Question Number" is important. For example, if reference is to a question with more than one part, do not enter the Question Number as "7"; use "7c" even though it may seem obvious.
2. Ensure all necessary signatures have been obtained (Proposed Insured, Witness) and, where forms require dating, the dates have been included.
3. Return all forms to the Agency/Producer within 2 days.



Massachusetts Mutual Life Insurance Company
and affiliates, Springfield, MA 01111-0001

www.massmutual.com



Application Part 2

To: Massachusetts Mutual Life Insurance Co. MML Bay State Life Insurance Co. C.M. Life Insurance Co.
 1295 State Street, Springfield, Massachusetts 01111-0001

1. Name _____ D.O.B. ____/____/____ S.S # _____ - _____ - _____

2. Height _____ Weight _____ lb If your weight changed by over 10 lb in the last year, indicate amount and reason _____

3. Name and Address of Personal Physician: _____

Phone number (if known) _____

4. Date last seen and reason: _____

5. Family History:

Relative	Health Problems — Include age at onset (especially for cardiovascular disease)	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

If your answer is "Yes" to any of the following questions, circle applicable item and explain in area provided (#14).

6. **Have you:** Yes No
- a. smoked cigarettes during the last 12 months?
 - b. used tobacco or products containing nicotine during the last 12 months?
 - c. used tobacco or products containing nicotine during the last 24 months?
7. **In the last 10 years have you consulted a health professional regarding:**
- a. chest pain, heart attack, high blood pressure, heart murmur, palpitations or any other disorder of the heart, arteries or veins?
 - b. a tumor or cancer including skin cancer, melanoma or colon polyps?
 - c. a disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma?
(Answer "N" if you have tested positive for HIV but have not developed symptoms of the disease AIDS)
 - d. a disorder of your brain, spinal cord or nervous system including seizures, tremors, paralysis, dizziness, fainting, headaches, stroke or TIA (transient ischemic attack)?
 - e. depression, anxiety, nervousness, stress, psychosis, suicide thoughts or attempts, anorexia or bulimia, post traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, or other emotional disorder?
8. **In the last 10 years have you:**
- a. used cocaine, barbiturates, narcotics, stimulants, hallucinogens or other controlled substances not prescribed by a physician?
 - b. received treatment, attended a program or been counseled for alcohol or drug abuse or been advised by a health professional to reduce the use of alcohol?
9. **In the last 5 years have you consulted a health professional regarding:**
- a. a disorder of your eyes, ears, nose, throat or sinuses including any partial or complete loss of hearing, vision or speech?
 - b. asthma, allergies, shortness of breath, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), pneumonia, sleep apnea, tuberculosis or any other disorder of your respiratory system?
 - c. a disorder of your digestive system, liver, pancreas or gall bladder including hepatitis, jaundice, ulcers, intestinal bleeding, colitis, Crohn's disease (ileitis), recurrent indigestion, diarrhea or diverticulitis?
 - d. a disorder or impairment of your muscles, bones, joints, nerves, spine, neck or back including arthritis, gout, sciatica or amputations?
 - e. Epstein-Barr virus, Lyme disease, chronic fatigue syndrome, fibromyalgia, lupus or other rheumatologic disorder?
 - f. diabetes or a disorder of your thyroid, pituitary or adrenal glands?
 - g. a disorder of your kidneys, bladder, prostate or urinary tract or findings of sugar, protein or blood in the urine?



Supplement "A" to Application Part 2

Name _____ D.O.B. ____/____/____ S.S.# _____

Question	Details and Medications	Name and Address of Physician

Witness
Signature _____

Proposed Insured's
Signature _____

Date _____

Printed Name _____

Paramedical and Medical Examinations for Insurance

Examination should be conducted in private and form completed by the examiner. For Medical Examination, clothing should be removed except undergarments. Breast, rectal and pelvic exams are not required. Examination with the stethoscope must be against the skin.

<p>1. Name (First, Middle, Last, Suffix)</p> <p>_____</p> <p>2. Height _____ ft. _____ in. Weight (clothed) _____ lb. (Both to be performed by the examiner)</p> <p>3. Blood Pressure</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%; text-align: center;">#1</td> <td style="width: 10%; text-align: center;">#2</td> <td style="width: 10%; text-align: center;">#3</td> </tr> <tr> <td>If BP exceeds 140/85, please record 2 additional readings</td> <td style="text-align: center;">Systolic</td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> <tr> <td></td> <td style="text-align: center;">Diastolic</td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table> <p>4. Pulse _____ / min. (note irregularities)</p> <p>▶ If Medical, continue with the following examination.</p> <p>If Paramedical, skip to #7 but provide detail of obvious limitations such as use of wheel chair, oxygen or inability of applicant to understand questions</p> <p>5. Heart</p> <p>a. Murmur: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic Grade <input type="checkbox"/> 1/6 <input type="checkbox"/> 2/6 <input type="checkbox"/> 3/6 <input type="checkbox"/> 4/6 <input type="checkbox"/> 5/6 <input type="checkbox"/> 6/6 Position and radiation:</p> <table style="width: 100%;"> <tr> <td></td> <td style="text-align: center;"><u>Yes</u></td> <td style="text-align: center;"><u>No</u></td> </tr> <tr> <td>b. Edema?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Evidence of enlargement, prior surgery or other findings?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>6. Any abnormality of the following:</p> <table style="width: 100%;"> <tr> <td>a. Head or neck including eyes, ears, nose, oral cavity and thyroid?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Lungs and chest?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Abdomen including surgical scars and organ enlargement?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Extremities including pulses?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Bones and joints including kyphosis, scoliosis and arthritis?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. Skin and lymph nodes?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. Nervous system including tremor, weakness and gait?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. Mental status including understanding and memory?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>i. Other?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		#1	#2	#3	If BP exceeds 140/85, please record 2 additional readings	Systolic				Diastolic				<u>Yes</u>	<u>No</u>	b. Edema?	<input type="checkbox"/>	<input type="checkbox"/>	c. Evidence of enlargement, prior surgery or other findings?	<input type="checkbox"/>	<input type="checkbox"/>	a. Head or neck including eyes, ears, nose, oral cavity and thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	b. Lungs and chest?	<input type="checkbox"/>	<input type="checkbox"/>	c. Abdomen including surgical scars and organ enlargement?	<input type="checkbox"/>	<input type="checkbox"/>	d. Extremities including pulses?	<input type="checkbox"/>	<input type="checkbox"/>	e. Bones and joints including kyphosis, scoliosis and arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	f. Skin and lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	g. Nervous system including tremor, weakness and gait?	<input type="checkbox"/>	<input type="checkbox"/>	h. Mental status including understanding and memory?	<input type="checkbox"/>	<input type="checkbox"/>	i. Other?	<input type="checkbox"/>	<input type="checkbox"/>	<p>Details to any positive findings. (Identify with question number)</p>
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7. Additional studies sent: Blood & Urine Urine only EKG ETT Other _____

8. Do you know the proposed insured? Yes No If yes, provide detail.

9. I completed the examination of the proposed insured on this date and the results of the examination are accurately recorded above.

X

Print name	Signature	Date
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10. Examiner address and identification _____ **Lab name, ID or bar code:** _____