Application Part 2 (A50VT)

Vermont Version

This application package may be used for:

- *Adults and Juveniles*

THIS PACKAGE INCLUDES:

- Part 2 of Application (A50VT702)
- 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

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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).

	Yes	No
6. Have you:		
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 (Excluding AIDS, ARC, HIV)?	☐	☐
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?	☐	☐

10. In the last 5 years have you consulted a health professional regarding:	Yes	No
a. a disorder of your skin including eczema, psoriasis or latex allergy?	☐	☐
b. a disorder of your uterus, cervix, ovaries or breasts?	☐	☐
c. multiple miscarriages, complicated pregnancy or infertility evaluation?	☐	☐
11. In the last 5 years, have you:		
a. had an application for life, disability or health insurance declined, postponed, rated or restricted?	☐	☐
b. had a sickness or injury for which you made a disability claim or for which you received payments, benefits or pension benefits?	☐	☐
c. been diagnosed as having AIDS or treated for AIDS by a licensed medical physician?	☐	☐
12. In the last 3 years, unless previously stated on this application, have you:		
a. had a physical exam, checkup or evaluation by a health professional? If yes, provide diagnosis or findings in #14 below.	☐	☐
b. had an injury treated by a health professional or medical facility?	☐	☐
c. had an electrocardiogram, x-ray, blood test or other diagnostic test, excluding an HIV test?	☐	☐
d. had surgery or been a patient in a hospital, clinic or other medical or mental health facility?	☐	☐
e. been advised to have surgery, medical treatment or diagnostic testing, excluding HIV testing, that has not been completed?	☐	☐
13. Are you currently:		
a. under treatment or taking any prescribed medication (other than contraceptives)?	☐	☐
b. taking any herbal or non-prescription medication at least weekly?	☐	☐
c. pregnant? (Expected delivery date: ____________________)	☐	☐

14. Details of "Yes" Answers. Identify the question by its number:
Give diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all health professionals. Supplement "A" should be attached, if necessary, to fully explain details.

Agreement and Signature

I agree that: (1) this application consists of Parts 1 and 2 and any amendments and supplements which shall be attached to the policy if issued; (2) no knowledge on the part of any agent, medical examiner or any other person as to any facts pertaining to me shall be considered as having been made to or brought to the knowledge of the Company unless stated in either Part 1 or Part 2 of this application or any amendments or supplements; and (3) to the best of my knowledge and belief, all information is complete, true, and accurate, and was correctly recorded before I signed my name below.

Signed at ______________________________ on ______________, 20 ____
City State Date

Witness Signature ______________________ Proposed Insured's Signature ______________________

Printed Name ______________________

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 ______________________

A50VT702

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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.

Details to any positive findings.
(Identify with question number)

1. **Name** (First, Middle, Last, Suffix)
____

2. **Height** ______ ft. ______ in. **Weight** (clothed) __________ lb.
(Both to be performed by the examiner)

3. **Blood Pressure**
If BP exceeds 140/85, please record 2 additional readings

	#1	#2	#3
Systolic			
Diastolic			

4. **Pulse** ____________ / min. (note irregularities)

▶ **If Medical, continue with the following examination.**

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

5. **Heart**

a. Murmur: ☐ Systolic ☐ Diastolic

Grade ☐ 1/6 ☐ 2/6 ☐ 3/6 ☐ 4/6 ☐ 5/6 ☐ 6/6

Position and radiation:

	Yes	No
b. Edema?	☐	☐
c. Evidence of enlargement, prior surgery or other findings?	☐	☐

6. **Any abnormality of the following:**

	Yes	No
a. Head or neck including eyes, ears, nose, oral cavity and thyroid?	☐	☐
b. Lungs and chest?	☐	☐
c. Abdomen including surgical scars and organ enlargement?	☐	☐
d. Extremities including pulses?	☐	☐
e. Bones and joints including kyphosis, scoliosis and arthritis?	☐	☐
f. Skin and lymph nodes?	☐	☐
g. Nervous system including tremor, weakness and gait?	☐	☐
h. Mental status including understanding and memory?	☐	☐
i. Other?	☐	☐

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

10. Examiner address and identification

____
____

Lab name, ID or bar code:

____
____