


**APPLICATION
PART II**

A Member of the Sammons Financial Group

Proposed Insured (Please Print)	First Name	M.I.	Last Name	Birth Date (Month, Day, Year)
1a. Name and address of personal physician (If none, so state)				Physician's Telephone Number
1b. Date and reason last consulted			1c. What treatment was given or medication prescribed?	

	Yes	No	
2. Have you			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.)
(a) Smoked cigarettes within the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Used tobacco in any other form within the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Received treatment for drug use or regularly used marijuana, narcotic, hallucinogenic or habit forming drugs not prescribed by a physician or are you currently using marijuana or such drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever had or been treated for			
(a) Chest pain, heart murmur, high blood pressure, or any other disease of the heart, blood, or blood vessels?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Peptic ulcer, indigestion, or any other disease of the stomach, intestines, gall bladder or liver?	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Emphysema, bronchitis, asthma, pleurisy, or any other disease of the chest or lungs? ...	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Kidney stone, diabetes; albumin, pus, blood or sugar in urine; sexually transmitted disease, or any other disease of the kidneys, bladder or reproductive organs?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Severe headaches, fainting spells, epilepsy, paralysis, nervousness, mental disorder, or any other disease of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Any impairment of sight or hearing?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Alcoholism or been treated or counselled for the use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
(h) Cancer, tumor or any other illness or injury not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you now under observation or taking treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you had any change in weight in the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other than above, have you within the past 5 years:			
(a) Had any mental or physical disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Had a checkup, consultation, illness, injury, surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Been a patient in a hospital, clinic, sanatorium, or other medical facility?.....	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Had electrocardiogram, X-ray, other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Been advised to have any tests, hospitalization or surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Family history: Diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?.....	<input type="checkbox"/>	<input type="checkbox"/>	
10. In the past 10 years, has any person proposed for insurance been treated for or been diagnosed as having Acquired Immune Deficiency Syndrome?.....	<input type="checkbox"/>	<input type="checkbox"/>	

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

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce the Midland National Life Insurance Company to issue the policy or contract applied for.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to Midland National Life Insurance Company, or its reinsurers, any such information. A reproduction of this authorization shall be as valid as the original.

Signed At (City and State)	Date
Witness Signature	Proposed Insured Signature

PART III – MEDICAL EXAMINER'S REPORT

10a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	b. Did you weigh? c. Did you measure? d. Is appearance unhealthy or older than stated age?	Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
11. Blood Pressure (Record ALL readings) Systolic Diastolic 5th phase			1st	2nd	3rd	12. Pulse Rate Irregularities per min.	At Rest	After Exercise	3 Minutes Later	
13. Heart: Is there any: Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Edema <input type="checkbox"/> Yes <input type="checkbox"/> No (describe below – if more than one, describe separately)					Please give your diagnosis of the lesion and any other comments.					
1st Murmur 2nd Murmur Location		Indicate:								
Constant <input type="checkbox"/> <input type="checkbox"/> Inconstant <input type="checkbox"/> <input type="checkbox"/> Transmitted <input type="checkbox"/> <input type="checkbox"/> Localized <input type="checkbox"/> <input type="checkbox"/> Systolic <input type="checkbox"/> <input type="checkbox"/> 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"/> After exercise: <input type="checkbox"/> <input type="checkbox"/> Increased <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/> <input type="checkbox"/> Unchanged <input type="checkbox"/> <input type="checkbox"/> Decreased <input type="checkbox"/> <input type="checkbox"/>		Apex by <input checked="" type="checkbox"/> X Murmur area by <input checked="" type="checkbox"/> O Point of greatest intensity by <input checked="" type="checkbox"/> O Transmission by <input checked="" type="checkbox"/> ↓								
14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)					Details of "Yes" answers. (Identify item.)					
(a) Eyes, ears, nose, mouth, pharynx? <input type="checkbox"/> Yes <input type="checkbox"/> No (If vision or hearing markedly impaired, indicate degree and correction.) (b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? <input type="checkbox"/> Yes <input type="checkbox"/> No (c) Nervous system (include reflexes, gait, paralysis)? <input type="checkbox"/> Yes <input type="checkbox"/> No (d) Respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No (e) Abdomen (include scars)? <input type="checkbox"/> Yes <input type="checkbox"/> No (f) Genitourinary system (include prostate)? <input type="checkbox"/> Yes <input type="checkbox"/> No (g) Endocrine system (include thyroid and breasts)? <input type="checkbox"/> Yes <input type="checkbox"/> No										
To be completed by either medical or paramedical examiner.										
1. How long have you known Proposed Insured? Yes No 2. Has the Proposed Insured ever consulted you professionally? . . . <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Are you related in any way to Proposed Insured or Agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Are you a business associate of either the Proposed Insured or Agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one and how associated? 5. Are you aware of any additional information which might have a bearing upon the Proposed Insured's insurability? <input type="checkbox"/> Yes <input type="checkbox"/> No (A confidential report may be sent to the Medical Director.)										
Send Urine Specimen To Laboratory In Container Provided. If Blood Specimen Is Required, Send To Laboratory In Kit Provided.										
Other Services Performed With This Examination: <input type="checkbox"/> Resting EKG <input type="checkbox"/> Treadmill EKG <input type="checkbox"/> Chest X-ray <input type="checkbox"/> DBS <input type="checkbox"/> Venipuncture <input type="checkbox"/> Other _____					Is urine specimen being sent to laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No Is person examined menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No					
I certify that I made this examination at _____ A.M. _____ P.M. on the _____ day of _____, _____					Examination made at <input type="checkbox"/> my office <input type="checkbox"/> Individual's Place of Business <input type="checkbox"/> Individual's Residence <input type="checkbox"/> Other _____					
Examiner's Signature					Examination Fee		Tax I.D. or S.S. No. (IMPORTANT: Payment cannot be made without number.)			
Examiner's Name (Print Full Name)					Examination Authorized By (Name of Agent – Please Print)					
Examiner's Address (Street, City, State, Zip)								Examiner's Telephone Number		

Disclosure of Test Results:

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. The results may also be reported to that insurance company's affiliates, agents, or reinsurers in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. If your HIV antibody test is negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Company as being positive, you are entitled to that information.

You are asked to name a private physician so that the Company can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

Address: _____

Consent:

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to provide a sample of my blood, urine and/or other body fluid testing, and the disclosure of the test results as described above.

Name of Proposed Insured

Date

Signature of Proposed Insured

State of Residence

AIDS COUNSELING SERVICES

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

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744 (209) 264-2436

AIDS Project Los Angeles
3670 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010 (213) 380-2000

Sacramento AIDS Foundation
1900 "K" Street, Suite 201
Sacramento, CA 95814 (916) 448-2437

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

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

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