

PART B: Medical Examiner's Confidential Report

Instructions to Examiner –

This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to the Proposed Insured. It should be sent to the home office upon completion.

Examination must be made in private. Proposed Insured must be properly prepared for careful physical examination. Please weigh and measure the applicant. Explain all positive findings under "Remarks". If for any reason you don't care to give certain special confidential information on this form, please enter such information on a separate sheet and mail directly to the Medical Director of the Company.

The questions, which appear below, are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though such information may not be specifically requested on this form.

1. Proposed Insured		REMARKS:
2. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other photo i.d.		
3. Height _____ ft. _____ in. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight _____ lbs. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Any change in weight over the past 12 months? If yes, reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Measurements (for males only) Chest: Full inspiration _____ in. Forced expiration _____ in. Abdomen: (at umbilicus) _____ in.		
5. Have you drawn a blood specimen and mailed it along with a urine specimen? Lab Name _____ If female, menses? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Blood Pressure: Initial reading _____ Additional readings _____ Report all readings. If initial reading is 140/90 or higher, or if the Proposed Insured has had hypertension or marked obesity, provide two additional blood pressure readings taken at intervals.		
7. Pulse Pulse at rest _____ Describe any irregularities _____ _____		
8. a. Does the Proposed Insured appear in any way unhealthy, or older than the stated age? b. Do you know of any facts bearing upon the risks, which are not brought out by the foregoing questions? c. Did you observe any other physical attributes such as, but not limited to, amputation, large area scars, etc.? d. Was anyone else besides the Proposed Insured present at time of exam? (If Yes, who?)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Are you acquainted with the Proposed Insured? If Yes, how well do you know the Proposed Insured? <input type="checkbox"/> Known well <input type="checkbox"/> Not known well <input type="checkbox"/> Relative (state relationship) _____ How long known? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART B: Medical Examiner's Confidential Report (continued)

10. Exam was done at: <input type="checkbox"/> Proposed Insured's office <input type="checkbox"/> Examiner's office <input type="checkbox"/> Proposed Insured's home <input type="checkbox"/> Other	REMARKS
--	------------------------

If a physician does examination, answer following questions.

11. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the: a. Brain or nervous system? (test reflexes and coordination) b. Eyes, ears, nose, or throat? c. Thyroid or lymph glands? d. Heart or blood vessels? (If there is a history of rheumatic fever, or if you find any abnormality of heart size, rhythm or sounds, please complete question 12) e. Lungs? f. Skin or extremities? g. Genitourinary system? h. Stomach or abdominal organs? i. Is the liver enlarged?	<table style="width:100%; border-collapse: collapse;"> <tr><td style="width:40%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
12. To be completed if question 11d is answered Yes or if requested: (Explain all Yes answers under "Remarks"). a. Is there a history of rheumatic fever or other infectious heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
b. Is there a history of congenital heart disease or other valvular abnormality?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
c. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
d. Is the first heart sound (S-1) normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
e. Is the second heart sound (S-2) normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
f. Are there gallops (S-3 or S-4)?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
g. Is/are there ejection sound(s) or systolic click(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
h. Is/are there murmur(s) present? <i>(If Yes, please describe under "Remarks", including timing systolic or diastolic), intensity (grades 1 through 6); location and transmission or radiation. Construct a chest diagram in "Remarks" if you wish)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No								
i. Your opinion of the murmur(s): <input type="checkbox"/> Innocent or functional <input type="checkbox"/> Mitral regurgitation <input type="checkbox"/> Mitral stenosis <input type="checkbox"/> Aortic insufficiency <input type="checkbox"/> Other (specify under "Remarks")									
13. Are you the Proposed Insured's personal physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No								

I HEREBY DECLARE that, to the best of my knowledge and belief, the statements and answers in Part B of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

Signature of Witness _____ Date _____
 Signed at (City & State) _____ Signature of PROPOSED INSURED _____

I certify that I personally asked each and every question on the Part B – and accurately recorded the answers thereon. I personally performed the physical measurements and observations recorded on this page.

Date of Examination _____ Signature of person completing form _____ Paramed MD

Paramedical Firm Name and Address (Print or Stamp) _____

Examiner: Print Examiner's Name _____ Examiner's phone number (_____) _____
 Address _____
 City, State Zip _____