

Application Part 2

MINNESOTA LIFE

Minnesota Life Insurance Company • Life New Business
400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed Insured Name (last, first, middle)	Date of Birth
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Agency That Arranged This Exam _____

	Yes	No										
1. A. Have you ever smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>										
<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <tr> <td style="width: 20%; padding: 2px;">Current Smoker</td> <td style="width: 20%; padding: 2px;">Past Smoker</td> <td style="width: 20%; padding: 2px;">Packs Per Day</td> <td style="width: 40%; padding: 2px;">Date Last Cigarette Smoked (MM, DD, YY)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>	Current Smoker	Past Smoker	Packs Per Day	Date Last Cigarette Smoked (MM, DD, YY)	<input type="checkbox"/>	<input type="checkbox"/>						
Current Smoker	Past Smoker	Packs Per Day	Date Last Cigarette Smoked (MM, DD, YY)									
<input type="checkbox"/>	<input type="checkbox"/>											
B. Have you ever used tobacco, other than cigarettes, in any form?	<input type="checkbox"/>	<input type="checkbox"/>										
<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <tr> <td style="width: 25%; padding: 2px;">What Type</td> <td style="width: 20%; padding: 2px;">Current User</td> <td style="width: 20%; padding: 2px;">Past User</td> <td style="width: 15%; padding: 2px;">How Much</td> <td style="width: 20%; padding: 2px;">Date of Last Use (MM, DD, YY)</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>	What Type	Current User	Past User	How Much	Date of Last Use (MM, DD, YY)		<input type="checkbox"/>	<input type="checkbox"/>				
What Type	Current User	Past User	How Much	Date of Last Use (MM, DD, YY)								
	<input type="checkbox"/>	<input type="checkbox"/>										
2. Are you taking or do you take any prescription or non-prescription medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>										
3. During the past 10 years have you had or been treated for:												
A. Seizures; epilepsy; paralysis; fainting spells; headaches; dizziness; sleep disorder; or any other disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>										
B. Depression; stress; anxiety; nervousness; nervous breakdown; or any other nervous, mental, or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>										
C. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>										
D. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>										
E. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	<input type="checkbox"/>	<input type="checkbox"/>										
F. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>										
G. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>										
H. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	<input type="checkbox"/>	<input type="checkbox"/>										
I. Cancer; tumor; or cyst?	<input type="checkbox"/>	<input type="checkbox"/>										
J. Anemia, leukemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>										
K. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>										
L. Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>										
M. Any physical deformity or defect?	<input type="checkbox"/>	<input type="checkbox"/>										
N. Any immune deficiency disorder including AIDS or AIDS-Related Complex (ARC), or AIDS-related conditions?	<input type="checkbox"/>	<input type="checkbox"/>										
O. A blood test showing evidence of antibodies to the AIDS (HIV) virus for the purpose of obtaining insurance?	<input type="checkbox"/>	<input type="checkbox"/>										
P. Any chronic or recurrent fever, fatigue or viral illness?	<input type="checkbox"/>	<input type="checkbox"/>										
4. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>										
5. During the past 10 years:												
A. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>										
B. Have you tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>										

Yes No

6. Other than above, have you in the past five years:

- A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.) Yes No
- B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility? Yes No
- C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test? Yes No
- D. Been advised to have any test, hospitalization, or surgery which was not completed? Yes No

7. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

8. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below. Yes No

Name		Phone Number	
Street Address			
City		State	Zip Code
Date Last Seen		Reason	

Give details of all yes answers, including doctors' names, addresses and dates.

I have read the statements and answers recorded on this Application Part 2; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Proposed Insured Signature	Date
X Witness	

Minnesota Life Insurance Company • Individual Policy Issues • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed Insured's Name (Last, First, Middle Name)	Date of Birth (Month, Day, Year)
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COMPLETE FOR ALL PARAMEDICAL EXAMINATIONS

1. Height In Shoes (Feet and Inches)	1A. Did You Measure The Proposed Insured? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. Weight Clothed LBS.	2A. Did You Weigh The Proposed Insured? <input type="checkbox"/> YES <input type="checkbox"/> NO
2B. Weight Change In The Past Year? LBS. <input type="checkbox"/> GAIN <input type="checkbox"/> LOSS		Cause?	
3. Waist (Relaxed) INCHES		4. Pulse Rate (At Rest) PER MINUTE	

5. Blood pressure (right arm while seated). If systolic is over 140 or diastolic is over 90 take a second reading at the end of the examination.

	FIRST READING	SECOND READING
SYSTOLIC	mm	mm
DIASTOLIC - 5th phase	mm	mm

6. Urinalysis

Specific Gravity	Albumin	Sugar
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Check appropriate box and send specimen only if:

- Requested by agent.
- Parent and/or sibling diabetic.
- History of renal disease or past or current elevated blood pressure.
- Abnormal findings on dipstick analysis.

7. Did you note any physical or mental impairment or abnormality? YES NO
If yes, please describe:

COMPLETE IF ADDITIONAL STUDIES REQUESTED

8. Electrocardiogram <input type="checkbox"/> ATTACHED <input type="checkbox"/> BEING SENT	9. Chest X-Ray <input type="checkbox"/> ATTACHED <input type="checkbox"/> BEING SENT	10. Other
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EXAMINER IDENTIFICATION

11. Which Paramedical Service Do You Represent?

Name X	Title	Date
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ADDITIONAL COMMENTS

CALIFORNIA NOTICE OF AIDS VIRUS ANTIBODY TESTING AND AUTHORIZATION FOR TESTING AND DISCLOSURE

To determine your insurability, the Insurer has requested a sample of your blood or other body fluid for testing and analysis. One of the tests to be performed will be to determine the presence or absence of antibodies to the HIV virus. Antibodies to the HIV virus are produced by the body when it has been infected by the HIV virus. Antibodies are the body's way of fighting the infection. This is not a test for AIDS. It is a test for antibodies to the HIV virus which causes AIDS, and shows whether you have been exposed to the virus. The HIV antibody test is actually a series of tests. These tests are extremely reliable. Your sample is first subjected to an ELISA (enzyme-linked immunosorbent assay) test. If the test is positive, a second ELISA test is performed. If the second test is positive, a Western Blot Test is performed. Your test result is considered positive only after positive results are obtained on all three tests.

A negative test result indicates that the antibody has not been found in your sample. If you test negative there are three possible explanations:

- You have not been infected with the virus; or
- You have had contact with the virus but have not become infected; or
- You have been infected by the virus but have not yet produced antibodies.

Research indicates that most people produce antibodies within 2 - 8 weeks after infection. A very small number of people will never produce antibodies.

A negative result does not mean:

- That you are immune to the virus;
- That you have not been infected with the virus. You may have been infected and have not yet produced antibodies.

A positive test result indicates that you have probably been infected with the AIDS virus and your body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. You may therefore assume you are contagious and capable of passing the virus to others. A positive test does not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. A positive test does not mean that you are immune to AIDS.

Normal test results will not affect your eligibility for insurance. A positive HIV antibody test will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. Negative test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you.

Public health authorities say that persons who are HIV antibody positive should be considered infected and capable of infecting others. Health authorities urge that everyone become educated about how to protect themselves from HIV infection. The virus is spread by sexual contact, needle sharing, or rarely through transfused blood or its components. The risk of infection with the virus is increased in drug users who share needles and in individuals with multiple sexual partners, either homosexual or heterosexual.

Most individuals infected with the virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever, including "night sweats"
- Weight loss for no apparent reason
- Swollen lymph glands in the neck, underarm, or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth

These symptoms are also symptoms of many other illnesses. They may be symptoms of the virus only if they are unexplained by other illnesses. People who are infected remain infected indefinitely and can pass the virus to others. Only a doctor and testing can tell if someone is infected with HIV, the virus that causes AIDS.

NOTIFICATION OF TEST RESULTS

If your HIV test results are positive or indeterminate, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, we ask that you give us the complete name and address of your physician. If your HIV test results are positive and you have chosen not to authorize a physician to receive the test results, we encourage you to contact a physician, the county department of health, the State Department of Health Services, local medical societies or alternative test sites for appropriate counseling. If your HIV test results are normal, no routine notification will be sent to you. If you wish to receive notice of the negative test results, please check here.

INFORMED CONSENT

I have read and understand this information statement. I voluntarily consent to have a blood or other bodily fluid sample taken. I consent to testing of that sample. I authorize the disclosure of the test results as described above.

NAME OF PROPOSED INSURED	SIGNATURE OF PROPOSED INSURED	DATE
BIRTHDATE	ADDRESS OF PROPOSED INSURED (Street, City, State, Zip)	

LISTING OF CALIFORNIA AIDS COUNSELING RESOURCES

San Francisco AIDS Foundation
 One Sixth Street at Market
 San Francisco, CA 94103
 (415) 487-3000

AIDS Services Foundation of
 Orange County
 17982 SkyPark Circle, STE J
 Irvine, CA 92614-6408
 (714) 253-1500

Sacramento AIDS Foundation
 1330 21st Street, Suite 100
 Sacramento, CA 95814
 (916) 448-2437

AIDS Project - East Bay
 651 20th Street
 Oakland, CA 94612
 (510) 834-8181

Central Valley AIDS Team
 1999 Tuolumne, Suite 625
 Fresno, CA 93744
 (209) 264-2436

AIDS Project Los Angeles
 1313 North Vine Street
 Los Angeles, CA 90028
 (323) 993-1600