

Medical Examination Form

In continuation of and forming a part of my application to Modern Woodmen of America



Proposed Insured: _____ Date of Birth: _____
 First Middle Last Suffix Month Day Year

1. Name of primary physician, clinic or health care provider: (if none, so state) _____
 Address: _____
 Street City State Zip Phone
 Reason last consulted (If checkup, indicate reason and outcome): _____
 Date last consulted: _____ What treatment was given or medication prescribed: _____

2. Have you lost weight in the past year? Yes No If YES, amount lost: _____
 Reason for weight loss? _____

Explain fully all "Yes" Answers to Questions 3 - 7. (Specify question and include diagnosis, treatment, results, recovery details, dates, durations, and names, addresses and phone numbers of all doctors and hospitals)

3. In the past 7 years, have you been treated or diagnosed by a physician for:	Yes	No
a. disease or disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
b. dizziness, fainting, convulsions, epilepsy, paralysis, stroke, sleep apnea, depression, anxiety, attempted suicide, or other mental or nervous disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. shortness of breath, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD) or other disease of the lungs or chronic respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. high blood pressure, cholesterol abnormality, chest pain, heart murmur, heart attack, arrhythmia, heart valve disorder, coronary artery disease or other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e. ulcer, colitis, intestinal bleeding, hepatitis, diarrhea of more than one week's duration, or other disease or disorder of the stomach, esophagus, intestines, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
f. sugar, protein or blood in urine or other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>
g. diabetes, leukemia, tumor, cancer, thyroid or glandular disorder, lupus, patches in mouth, skin rash or other disease or disorder of the skin?	<input type="checkbox"/>	<input type="checkbox"/>
h. neuritis, neuropathy, arthritis, back disorder, amputation or other disease or disorder of the muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>
i. allergies, anemia, fever persisting over one month, swollen glands in the neck, armpits or groin or other blood or lymph disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j. disorder of prostate, reproductive organs or breasts or a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
k. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently receiving treatment or taking any medication or herbal supplements as prescribed or directed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you within the past 7 years:		
a. used marijuana, cocaine, methamphetamine, heroin, sedatives, stimulants, hallucinatory drugs, opiates, narcotics, or prescription medications other than as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
b. received or been advised to seek counseling, treatment, or been arrested for the use or possession of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. Other than as stated in answers to Questions 1-5 of this examination, have you within the last 7 years:		
a. consulted, been examined or treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
b. had any illness, injury or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. been a patient in or been examined or treated at a hospital, clinic, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. had an electrocardiogram (EKG), biopsy, heart study, colonoscopy, pap smear, mammogram, blood test, sleep study, x-ray or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
e. been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
7. To the best of your knowledge, have any of your parents, brothers or sisters ever had cancer, diabetes, high blood pressure, stroke, Huntington's disease, polycystic kidney disease, heart disease, or other cardiovascular disorder before age 60? (If YES, specify person, condition, and age at death if deceased)	<input type="checkbox"/>	<input type="checkbox"/>
8. Age 18 & up Have you used any nicotine or tobacco products in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used any nicotine or tobacco products in the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>

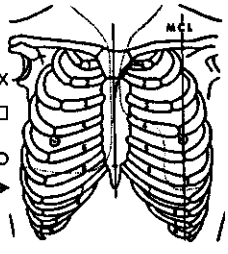
Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false, deceptive, incomplete, or misleading statement may be guilty of a crime.

Date: _____ State signed in: _____

Medical Examiner: _____ Applicant Signature: _____

Proposed Insured: _____ Date of Birth: _____
 First Middle Last Suffix Month Day Year

Medical Examiner's Report

9. Height: _____ feet _____ inches Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____ Weight: _____ pounds Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____ The scale used accurately weighs to _____ pounds.		
10. Pulse at rest: _____ Irregularities: _____ If pulse is irregular, exercise sufficient to increase pulse rate to 100 or more and record response: Pulse after exercise: _____ Irregularities: _____ Pulse 3 minutes later: _____ Irregularities: _____		
11. Blood pressure: Please record three readings		
	First Reading	Second Reading
Systolic	_____	_____
Diastolic	_____	_____
	Yes	No
12. Is appearance unhealthy or older than stated age?	<input type="checkbox"/>	<input type="checkbox"/>
13. Any obvious physical or mental impairments?	<input type="checkbox"/>	<input type="checkbox"/>
14. Is there on examination any abnormality of the following: (Circle applicable item and give details)		
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (include scars), lymph nodes, varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>
15. On heart examination, is there any murmur?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe location: _____ Mark all that apply: <input type="checkbox"/> Constant <input type="checkbox"/> Inconstant <input type="checkbox"/> Transmitted <input type="checkbox"/> Localized <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Grade 1-2 <input type="checkbox"/> Grade 3-4 <input type="checkbox"/> Grade 5-6		
Indicate: Apex by X Murmur area by <input type="checkbox"/> Point of greatest intensity by O Transmission by ▶		
		
Give Comments and Your Impression in detail space.		
16. Are you aware of additional medical history?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers (Specify question)
 (Do not write details from page 1 in this area. If needed, continue on a separate signed and dated form.)

I certify that the above report is a record of an examination made by me of the applicant on: Date _____
 Examiner's Name: _____ Examiner's Signature: _____
 Examiner's Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____
 Company: _____ Fee: \$ _____ Agent's Name: _____



Fraternal Financial Services
HOME OFFICE: 1701 1ST AVENUE, ROCK ISLAND, ILLINOIS 61201
800-447-9811 www.modern-woodmen.org

Instructions to the Examiner for Medical Examination Form 2502

1. Authorization is given for completion of the attached examination form only. Additional fees for tests not specifically authorized will not be honored.
2. This form is to be used for ages 16 and above.
3. Examinations must be made in private. Field representatives and/or family members **should not** be present during the examination.
4. All examination questions must be asked by the Medical Examiner and answers should be printed by the examiner. Any changes should be initialed by the proposed insured.
5. If the proposed insured does not speak fluent English and an interpreter is required to complete the examination, the Medical Examiner should note the relationship of the interpreter to the proposed insured and the language spoken on page 2 of the examination. The interpreter must be a disinterested adult (someone other than the field representative or beneficiary).
6. If explanations on page 1 do not fit on that page, continue on a new exam or separate sheet which is signed and dated. Do not put those details on page 2. All answers and explanations given for questions on page 1 must be above the proposed insured's signature and dated.
7. The proposed insured must sign the examination form in the Examiner's presence. Examiner should verify the identity of the proposed insured with a valid picture ID.
8. The Medical Examiner's Report (page 2) must be completed and signed by the Medical Examiner. The information on the bottom of page 2 constitutes your bill for service.
9. Return pages 1-2 of this examination to the appropriate address given below. If you are contracted through an approved paramed service, please follow the instructions given by your Home Office. If you are the applicant's physician, please mail.
10. For physicians, mail all requirements to:

For Non-variable Products

MEDICAL DIRECTOR
Modern Woodmen of America
1701 First Avenue
Rock Island, IL 61201

For Variable Products

Modern Woodmen of America
Variable Product Administrative Center
PO Box 9284
Des Moines, IA 50306-9284

11. Blood and urine specimens should be sent to: Heritage Labs, Inc.
1111 W. Old Highway 56
Olathe, KS 66061
Ph. (888) 764-4120