



MTL INSURANCE COMPANY

1200 Jorie Boulevard • Oak Brook, Illinois 60522-9060

Part II of application to MTL Insurance Company - Answers made to Medical Examiner

1. PRINT Full Name and Date of Birth

Born:

First	Middle	Last	Month	Day	Year		
2. Have you, in the past 10 years been advised of, had known indication of, sought consultation for, or been treated for:		Yes	No	b. Have you smoked any cigarettes in the past 12 months?		Yes	No
a. Convulsions, seizures, paralysis, stroke, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?			c. Have you used tobacco in any other form in the past 12 months?				
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, or persistent shortness of breath?			7. Are you now under observation by a physician or taking any prescription medication(s)?				
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?			8. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease, or mental illness?				
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?			Father	Age if living	Cause of Death	Age at Death	
e. Sugar, albumin, blood or pus in urine, venereal disease, or other disorder of the kidney, bladder, prostate, breasts or reproductive organs?			Mother				
f. Diabetes, thyroid or other endocrine disorder?			Brothers & Sisters				
g. Arthritis or disorder of the muscles or bones, spine, back or joints?			No. Living				
h. Disorder of skin, lymph glands, cyst, tumor or cancer?			No. Dead				
i. Disorder of the eyes, anemia or other disorder of the blood?			9. DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS. Include diagnoses, prescription medication(s), dates, duration, and names and addresses of all attending physicians and medical facilities.)				
3. Have you, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	Yes	No					
4. Have you in the past 10 years:	Yes	No					
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?							
b. Been advised to seek, or received counseling or treatment, or attended or joined any group for alcohol or drug dependence?							
5. Other than above, have you in the past 5 years:	Yes	No					
a. Had any mental or physical disorder, illness, injury or surgery?							
b. Had a checkup or other consultation?							
c. Been a patient in a hospital, clinic, medical center or other medical facility?							
d. Had an EKG, stress test or any other diagnostic test?							
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?							
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?							
If more space is needed, attach on separate page.							
6a. Have you lost or gained more than 15 lbs. in the past year? If "yes," indicate reason and amount of gain or loss.	Yes	No					

MEDICAL EXAMINER'S REPORT
(Both sides of this form are to be completed by the Medical Examiner)

1. a. Height (in shoes)	Scale Weight (clothed)		Males Only:			9. Details of "Yes" answers. (Identify item.)
	ft.	in.	lbs.	Chest (full inspiration) in.	Chest (forced expiration) in.	

b. Did you weigh? Yes No Did you measure? Yes No
 c. Is appearance unhealthy or older than stated? Yes No

2. Blood Pressure: (If systolic reading over 140 or diastolic over 90, or if Insured is markedly overweight, obtain three readings at intervals.)

Initial	Additional Readings
Systolic	
Diastolic	
(5 th Phase)	

3. Pulse:

At Rest	After Exercise	3 Minutes Later
Rate _____		
Irregularities per minute _____		

4. Heart: Is there any:

Enlargement Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No
 (Describe below - if more than one, describe separately.)

Location								
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:								
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"/>						

Indicate: MCL ↓

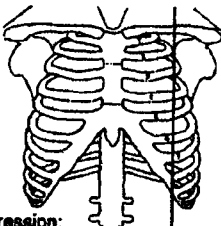
Apex by X

Murmur area by □

Point of greatest intensity by ○

Transmission by →

For comment and your impression:



5. Is there on examination any abnormality of the following:
 (Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx?.....	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries? ...	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis, tremors)?.....	<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 (include prostate)?	<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, amputation, deformities?)	<input type="checkbox"/>	<input type="checkbox"/>

6. Are there any hernias? Yes No

7. Are you aware of additional medical history? Yes No (A confidential report may be sent to the Medical Director.)

8. Have you known Insured previously? Yes No

Urinalysis: Specific Gravity	Albumin	Sugar	Send urine specimen if Insured is applying for \$100,000 or more of life insurance, or is (a) hypertensive or has other cardiovascular abnormalities, (b) markedly overweight, or (c) age 60 and over.
Is specimen being sent to Company lab? <input type="checkbox"/> Yes <input type="checkbox"/> No			Send 2 specimens (different days) if albumin, sugar, pus, blood or casts are present, or were found in past.

I have examined the Proposed Insured in private at: My Office Proposed Insured's Residence
 Proposed Insured's Place of Business _____

At _____ A.M./P.M. Date _____ M.D.

Medical Examiner

I have read the statements and answers recorded above which have been made by me in continuation of and as part of the application for insurance. I hereby represent that such statements and answers, to the best of my knowledge and belief, are complete and true. I agree that they shall be a basis for any contract of insurance that may be issued.

Dated at _____ Date signed _____

Witness _____ Insured _____

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 the MTL Insurance Company any such information. This authorization shall permit the above named company, its reinsurer(s) or its representative, and any consumer reporting agency to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. A photocopy of this authorization shall be as valid as the original. This authorization expires two years after the date of the policy. I acknowledge receipt of the disclosure statements regarding the investigative consumer report and the Medical Information Bureau, and authorize the company to obtain a consumer investigative report if deemed necessary.

Date _____

Witness _____ Insured _____

Form No. 6330-93

Mail this form to: MTL Insurance Co., Underwriting Department, 1200 Jorie Blvd., Oak Brook, IL 60522-9060

DO NOT DETACH

VOUCHER FOR MEDICAL EXAMINATION

DO NOT DETACH

Please Print

Name of person examined _____ Fee _____

Date examined _____ Name of Agent _____

Name of examiner _____ Soc. Sec. No. _____

Address of examiner _____

STREET AND NUMBER

OFFICE PHONE NUMBER

CITY AND STATE

ZIP