

This Medical History - Application Part II shall amend and be made a part of the undersigned's Application for Insurance to National Western Life Insurance Company, 850 East Anderson Lane, Austin, Texas 78752-1602

Proposed Insured (Photo I.D)			Birth Date (Month/Day/Year)	Age
First	Middle	Last		

1. When did you last consult a Physician? Date _____ Reason _____
 Name of Physician _____ Address _____
2. Name of Family Physician _____ Address _____

3. Family History of Proposed Insured	Age if Living	Age at Death	Cause of Death if Deceased or State of Health if Living	Number Living	Number Deceased	Cause of Death if Deceased
Wife or Husband				Brothers		
Mother				Sisters		
Father						

4. During the last 12 months, have you used any tobacco or nicotine product? YES NO
5. Have you ever had, or received medical advice or treatment for:
- A. High blood pressure, stroke, anemia, chest pain, heart attack, disease or disorder of the blood, heart, arteries or veins? YES NO
 - B. Ulcers, or disease or disorder of the stomach, intestines, liver, gallbladder or rectum? YES NO
 - C. Diabetes, cancer, tumors, cysts, leukemia, or disorder of the pancreas, thyroid, adrenal, lymph or other glands? YES NO
 - D. Epilepsy, convulsions, nervous or mental disorder, paralysis, or disorder of the brain or nervous system? YES NO
 - E. Disease of the kidney, bladder, genital organs, or had sugar, albumin, or blood in the urine, or had gonorrhea or syphilis? YES NO
 - F. Asthma, emphysema, tuberculosis, chronic bronchitis, or disease of the lung, chest or throat? YES NO
6. Have you lost or gained more than 10 lbs. during the past 12 months? YES NO
7. Other than as answered above, have you within the past 5 years:
- A. Consulted a health care provider, or been admitted to a hospital, treatment center, or other facility? YES NO
 - B. Been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS)? YES NO
 - C. Had an X-ray, ECG, blood or urine test, or other diagnostic medical test? YES NO
 - D. Requested or received payments or reimbursements for a mental or physical disability? YES NO
 - E. Been advised to have surgery, hospitalization, treatment, or diagnostic test that has not been completed? YES NO
 - F. Taken medication for any disease, disorder or condition not indicated above? YES NO
 - G. Been treated or counseled by a health care provider for alcohol use or ever used illegal drugs? YES NO

PART II DETAILS: Please provide complete details for all "yes" answers above.

Ques. No.	Reason For Treatment	Date	Name of Doctor or Hospital And Address
If more space is needed, use an additional sheet of paper, dated and signed by the proposed insured.			

I declare that the answers above are true and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____, 20 _____

Witness _____ M.D. _____
 Signature of Medical Examiner Signature of Proposed Insured

PHYSICAL EXAM REPORT - PART III

THE PROPOSED INSURED MUST BE IDENTIFIED BY A PHOTO I.D.

1. **A.** Height (In shoes) ft. _____ in.
 Weight (Clothed) lbs. _____
 Chest (Full Inspiration) Males Only in. _____
 (Forced Expiration) in. _____
 Abdomen, at Umbilicus in. _____
- B.** Did you weigh? Yes No
 Did you measure? Yes No
- C.** Is appearance unhealthy or older than stated age? Yes No
2. Blood Pressure - *Record 2nd and 3rd readings at intervals during exam if history of hypertension or if 1st reading is 140 systolic or 90 diastolic or greater.

	1st Reading	*2nd Reading	*3rd Reading
Systolic			
Diastolic			
Pulse Rate			
Beat Irregularities per min.			

3. Is there on examination any abnormality of the following? (Circle applicable items and give details.) Yes No
- A.** Heart or Blood Vessels (For murmur give location, timing, transmission, your diagnosis, etc. For enlargement or edema, give degree.)
- B.** Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)
- C.** Skin (include scars); lymph nodes, varicose veins or peripheral arteries?
- D.** Nervous system (include reflexes, gait, paralysis)?
- E.** Respiratory system?
- F.** Abdomen (include scars)?
- G.** Genitourinary system (include prostate)?
- H.** Endocrine system (include thyroid and breasts)?
- I.** Musculoskeletal system (include spine, joints, amputations, deformities)?
4. Are you aware of additional medical history?
 (A confidential report may be sent to the Medical Director.)
5. Urine: (Not required when specimen is sent to insurance company lab.)
- A.** Specific Gravity _____
- B.** Albumin _____
- C.** Sugar _____
- D.** Have you sent a specimen to the Insurance Company Laboratory? _____

Ques. No.	Details of "Yes" answers to Questions 1C, 3, 4 and/or 5

I certify that I have carefully examined _____ of _____ and they have been identified by a photo I.D. (City and State)

How long have you known the proposed insured? _____ Are you related to proposed insured or agent? _____

Examined at: Office His place of business His home this _____ day of _____, 20 ____ at _____ a.m. p.m.

Signature of Examiner ✕ _____ Print Examiner Name _____

Examiner Address _____

Medical School _____ Year Graduated _____

Medical Specialty _____ Your Fee for this exam \$ _____

Agent's Name who authorized exam _____ Examiner's Phone Number _____

Please make sure that this Report is accurately and fully completed. Mail directly to the Medical Director at the Home Office of the Company.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, other health care provider, insurance company or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. National Western or its reinsurers may also release such information to the MIB or to other life and health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. The Medical Information Bureau may furnish directly to National Western or its reinsurers any records or knowledge of me or my health. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photo of this form is valid as the original. I may have a copy of this form upon request.

Signature of Proposed Insured ✓ _____ Date _____ 20 _____

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named below (the Insurer) has requested that you provide a sample of your blood or oral fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. The oral fluids test is not as reliable as the blood test. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Counseling Resources

You can obtain assistance in understanding the meaning of the test and its results by calling the California State Aids Hotline, 1-800-367-2437. The multilingual hotline can give you a state funded counseling site closest to you.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, 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 result means, you are asked to list your private physician so that the Insurer 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: _____

If you do not wish to know the results of the test, initial here: _____ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____ The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here: _____ The result will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS Testing. I voluntarily consent to the withdrawal from me of: (Place a check mark for your choice.)

Blood _____ or Oral fluid _____

I also consent to the testing of that blood or oral fluids and the disclosure of the test results as described above.

I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed