



NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
 NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
 NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Part II

First Name _____ Middle Name _____ Last Name _____ Male Female Date of Birth (mm/dd/yyyy) _____

Social Security No. or Tax ID No. Exempt Applied for _____ Policy No./Tracking No. _____

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (____) _____ - _____
 Date of last visit: ____/____/____ Reason for visit : _____

Treatment or medication provided: (Provide details and/or name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include dosage and frequency) _____

3. In the last ten (10) years, has the proposed insured had, been told he/she has, or been treated for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse?..... Yes No
 - b. Elevated blood sugar or diabetes?..... Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder?..... Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma?..... Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder?..... Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder?..... Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder?..... Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA?..... Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder?..... Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder?..... Yes No
 - k. Any psychiatric or mental health condition (including counseling or hospitalization)?..... Yes No
 - l. Drug or alcohol use, or used cocaine or other controlled substances, or been counseled or hospitalized for drug or alcohol use?..... Yes No
4. In the last ten (10) years, has the proposed insured had or been treated for HIV positive results or AIDS (Acquired Immune Deficiency Syndrome)? Yes No
5. In the last two (2) years, other than as already stated, has the proposed insured:
- a. Had any surgery or been recommended to have surgery?..... Yes No
 - b. Had any diagnostic tests or been recommended to have any diagnostic test other than already stated ?
 (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy)..... Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more?..... Yes No
6. Among proposed insured's natural parents, brothers or sisters, is there any history of angina, heart disorder or stroke?
 (If "Yes", please provide relationship, age of onset and subsequent history in details below.)..... Yes No
7. Has proposed insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.)..... Yes No
8. Height ____ft. ____in. Weight ____lbs.

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use another form.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset		Recovery		Doctors, Hospitals and Medical Facilities Info
		Mo.	Year	Mo.	Year	

THE UNDERSIGNED DECLARE THAT, to the best of their knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true.

Dated at _____ on ____/____/____
 (City, State) (mm/dd/yyyy) Signature of person examined

Signature of Parent or Guardian, if person examined is under age 14 years and 6 months _____
 Witnessed by _____

- Insurer
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NOTICE AND CONSENT FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your insurability, the Insurer named above (the Insurer) needs a sample of your body fluid to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form you agree to submit a sample of body fluid. Testing may be done, and the test result will be used in reaching an underwriting decision.

Explanation of Test and the Meaning of the Test Result

This is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been infected by the virus. The test is done by a medically accepted procedure which has been approved by the Food and Drug Administration which includes both screening and confirmatory tests and is extremely reliable. A positive test result does not mean that you have AIDS but that you have been exposed to the virus and you are at significantly increased risk of developing AIDS or AIDS-related conditions. Persons who are HIV positive should be considered infected with the AIDS virus for life and capable of infecting others. An indeterminate test result may mean that you have been exposed to the HIV virus but it also may be due to a cause unrelated to the virus.

A positive HIV antibody test result will mean that your application for insurance will be declined. An indeterminate test result may mean that your application will be declined but, if so, you may submit another application and test in six months.

Limitations of Test Results

An HIV antibody/antigen test will be considered positive only after confirmation by a laboratory procedure that has been determined to be highly accurate. Although rare, possible errors include:

- a. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens only rarely, usually in recently infected person. (It takes at least 4-12 weeks for a positive test result to develop after a person is infected.)
- b. **False positives:** The test gives a positive result, even though you are not infected. This is exceedingly rare and is more common in persons who have not engaged in high risk behavior.

Confidentiality of Test Result

The test result will be treated confidentially. The test may be disclosed to:

1. employees of the Insurer who have the responsibility to make underwriting decisions on behalf to the Insurer.
2. a reinsurer, if the reinsurer is involved in the underwriting process,
3. an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of a general code that also covers results of tests for other diseases or conditions not related to AIDS,
4. outside legal counsel who needs such information to effectively represent the Insurer in regard to your application, or as otherwise required by law,
5. persons preparing statistical reports that do not disclose identity.

Report of Test Result

If your test result is negative, no routine report will be made. If your test result is reported by the laboratory to the Insurer as being positive or indeterminate resulting in an adverse underwriting decision, the result will be sent to a physician that you designate. You are asked to list below a physician of your choice so that this physician can tell you the test result and explain its meaning.

Physician to whom a possible positive, reactive or indeterminate test result will be reported:

Name: _____

Address: _____

Consent

I have read and I understand the Notice and Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of body fluid from me, the testing of that fluid, and the reporting of the test result as described above. A photocopy of this form will be as valid as the original.

Name of Proposed Insured

Signature of Proposed Insured

Date Signed