

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE

P.O. Box 466 • Chicago, Illinois 60690-0466

PLEASE USE BLACK INK

Application Part II

Proposed Insured Birth Date: Month Day Year

1. (a) Name and address of your personal physician?
 (b) Date and reason last consulted within past 5 years?
 (c) State what treatment was given or medication prescribed?

2. Have you ever been treated for or ever had any known indication of:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| (a) Disease or disorder of eyes, ears, nose or throat? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Chest pain, palpitation, high or elevated blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disease of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Diabetes, thyroid or other endocrine disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Neuritis, sciatica, rheumatism, arthritis, gout, or disease or disorder of the muscles or bones, including the spine, back, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Deformity, lameness or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Disease or disorder of skin, lymph glands, cyst, tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Allergies, anemia or other disease or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Mental, nervous or emotional disorders, depression or attempted suicide? | <input type="checkbox"/> | <input type="checkbox"/> |

8. Other than above, have you within the past 5 years:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| (a) Had a checkup, consultation, illness, injury or surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Been a patient in a hospital, clinic, sanatorium, or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Had an electrocardiogram, X-ray or other medical test? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Been advised to have any medical test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |

9. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

10. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

11. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental disorder or attempted suicide?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

	Age if living?	Cause of death	Age at death?
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

DETAILS OF "YES" ANSWERS: IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses dates, duration and names and addresses of all attending physicians and medical facilities. If necessary the space on back of this form may be used.

3. Have you ever:
- | | | |
|---|--------------------------|--------------------------|
| (a) Had diagnostic blood studies, other than to determine the presence of Aquired Immune Deficiency Syndrome (AIDS) or AID Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had diagnostic studies done to evaluate his or her immune mechanisms, other than for AIDS or ARC? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Been diagnosed as having or been treated in reference to diseases related to his or her immune system other than for AIDS or ARC? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Been diagnosed as having or been treated for AIDS or ARC? | <input type="checkbox"/> | <input type="checkbox"/> |

4. During the past 24 months, have you been under observation, received treatment, consultation or therapy of any kind?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

5. Have you ever sought treatment, consultation or therapy for or been advised concerning a drug or alcohol problem? ..
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

6. Have you ever:
- | | | |
|--|--------------------------|--------------------------|
| (a) drunk beverages containing alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) smoked or used tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) used marijuana, cocaine, any narcotic or controlled substance or illicit drug? | <input type="checkbox"/> | <input type="checkbox"/> |
- In explaining any "Yes" answer to this question, state what was drunk, smoked or used, how much and how often.

7. Have you had any change in weight or height in the past year?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

12. Females only:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| (a) Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If "yes", what month? | <input type="checkbox"/> | <input type="checkbox"/> |

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application, made part of the policy or contract, if issued and are made to induce North American Company for Life and Health Insurance to issue the policy or contract applied for.

Dated at Signature of Proposed Insured
 on / / Witness: M.D.
 MONTH DAY YEAR Signature of Medical Examiner

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or Medical Information Bureau that has any records or knowledge of me or my health or of any member of my family, to give North American Company for Life and Health Insurance or its reinsurers any such information. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for insurance. To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by North American Company for Life and Health Insurance to collect and transmit such information. A photographic copy of this authorization shall be as valid as the original. This authorization is effective for thirty months from the date it is signed.

L-644-74JAN86(4)

R1 1/00

DO NOT DETACH THIS VOUCHER

THIS VOUCHER SERVES AS BASIS FOR PAYMENT OF THIS EXAMINATION TO FACILITATE CREDITING FEE, PLEASE COMPLETE EACH SPACE IN THIS VOUCHER

Please indicate your usual and customary charge.
 \$ _____

Name of examiner (Print) _____ Name of Applicant _____
 Address of examiner _____ Name of Agent _____
 Date of examination _____ Amount of Insurance _____
 If not a regular appointed examiner of the Company, state where graduated _____ Date of graduation _____
 Name of companies for which you examine? _____
 Federal tax ID number _____

MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details

PROPOSED INSURED	Are you related to the agent or proposed insured? _____ If yes, give relationship.
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10. (a)	Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen at Umbilicus in.
(b) Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
(c) Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No					

17. If underwriting rules require, was blood drawn? Yes No

18. If blood drawn, what was last meal and when? _____

19. Based on your examination would you refer the Proposed Insured for further medical evaluation? Yes No

11. Blood Pressure (Record ALL readings)
If initial reading over 140/90, take 2 additional readings, 5 minutes apart.

Systolic (4th phase)			
Diastolic (5th phase)			

Details of "Yes" answers (Identify item.)

12. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart: is there any;

Enlargement Yes No Dyspnea Yes No

Murmur(s) Yes No Edema Yes No

(If "Yes", describe below; if more than one, describe separately)

Location: Indicate:

Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	<input checked="" type="checkbox"/>	
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	<input type="checkbox"/>	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	<input type="checkbox"/>	
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	<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: Diagnosis:

Increased _____

Absent _____

Unchanged _____

Decreased _____

14. On examination is there 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 (incl. 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 (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, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

15. (a) Are there any hernias?

 (b) Any hemorrhoids?

16. Are you aware of additional medical history?
(A confidential report may be sent to the Medical Director)

Urinalysis:	Specific Gravity	Albumin	Sugar

Lab to which specimen sent: H.O.R.L. G.I.B.
(Do not send to North American Home Office)

URINALYSIS RULES

EXAMINER: USE THE FOLLOWING RULES FOR SUBMITTING SPECIMEN TO LAB:

AGE	SPECIMEN IF AMOUNT EXCEEDS:
0-40	250,000
41-60	100,000
61 and up	50,000

ALSO, SEND SPECIMEN REGARDLESS OF AMOUNT IF:

1. BLOOD PRESSURE EXCEEDS 145/90
2. ALBUMIN OR SUGAR FOUND OR SUSPECTED OR IF THERE IS HISTORY OF SAME
3. APPLICANT IS PREGNANT
4. THERE ARE ANY FINDINGS OF KIDNEY, PROSTATE, BLADDER OR GENITOURINARY DISEASE
5. FAMILY HISTORY OF DIABETES

I certify that I made this examination at A.M. P.M. on the _____ day of _____ Date _____

Examination made at: my office Individual's office Individual's Home Other: _____

Examiner's Signature: _____ Examiner's Address: _____



North American Company
for Life and Health Insurance
P O Box 87452 . Chicago, IL 60680 - 0452



NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

The Tests:

To evaluate your eligibility for insurance, the insurer named above has requested that you provide a sample of your blood, urine and/or other body fluid for testing and analysis to determine the presence of human Immunodeficiency virus (HIV) antibodies. 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 tests will be performed by a certified laboratory through medically accepted procedures.

Meaning of Test Results:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application. An HIV test will be considered positive only after confirmation by a laboratory procedure which is extremely reliable. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

False Positives: the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.

False Negatives: the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Side Effects:

A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contacting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Disclosure of Test Results:

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. The results may also be reported to that insurance company's affiliates, agents, or reinsurers in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. If your HIV antibody test is negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Company as being positive, you are entitled to that information.

You are asked to name a private physician so that the Company 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: _____

Consent:

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to provide a sample of my blood, urine and/or other body fluid testing, and the disclosure of the test results as described above.

Name of Proposed Insured

Date

Signature of Proposed Insured

State of Residence

AIDS COUNSELING SERVICES

AIDS Project - East Bay
400 - 40th Street, Suite 20
Oakland, CA 94609 (415) 420-8181

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744 (209) 264-2436

AIDS Project Los Angeles
3670 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010 (213) 380-2000

Sacramento AIDS Foundation
1900 "K" Street, Suite 201
Sacramento, CA 95814 (916) 448-2437

AIDS Services Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627 (714) 646-0411

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103 (619) 543-0300

ARIS Project
595 Millich Drive, Suite 104
Campbell, CA 95008 (408) 370-3272

San Francisco AIDS Foundation
25 Van Ness Avenue, Suite 660
San Francisco, CA 94102 (415) 864-5855