

**NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE**  
P O Box 87452 Chicago, IL 60680-0452

Application Part II

PLEASE USE BLACK INK

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, 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"/> |
| (m) Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or "AIDS" related conditions? .....                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Have you received counseling or treatment connected with any of the conditions mentioned in (m) above? .....                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |

8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? ..... Yes No

9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? ..... Yes No

10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental disorder or attempted suicide? ..... Yes No

|                      | 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. During the past 24 months, have you been under observation, received treatment, consultation or therapy of any kind? ..... Yes No

4. Have you ever sought treatment, consultation or therapy for or been advised concerning a drug or alcohol problem? ..... Yes No

5. 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.

6. Have you had any change in weight or height in the past year? ..... Yes No

7. Other than above, have you within the past 5 years:
- |                                                                                                       |                          |                          |
|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| (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"/> |

11. 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? .....                                                                         |                          |                          |

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, the Medical Information Bureau or other organization, institution or person, 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.

L-644-74JAN86

R2 5/02

**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 .....

**TO MEDICAL EXAMINER**

The medical questionnaire is to be completed by the Medical Examiner in his own handwriting, signed in his presence, and witnessed by him.

**MEDICAL EXAMINER'S REPORT**

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

|                         |                                                                                       |
|-------------------------|---------------------------------------------------------------------------------------|
| <b>PROPOSED INSURED</b> | Are you related to the agent or proposed insured? _____<br>If yes, give relationship. |
|-------------------------|---------------------------------------------------------------------------------------|

|                                                                                                                                                                            |                                    |                             |                                    |                                     |                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------|------------------------------------|-------------------------------------|--------------------------------|
| <b>10. (a)</b>                                                                                                                                                             | Height<br>(In Shoes)<br>ft.    in. | Weight<br>(Clothed)<br>lbs. | Chest (Full<br>Inspiration)<br>in. | Chest (Forced<br>Expiration)<br>in. | Abdomen at<br>Umbilicus<br>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<br>(4th phase)  |  |  |  |
| Diastolic<br>(5th phase) |  |  |  |

Details of "Yes" answers (Identify item.)

**12. Pulse:**

|                         |         |                |                 |
|-------------------------|---------|----------------|-----------------|
|                         | At Rest | After Exercise | 3 Minutes Later |
| Rate                    |         |                |                 |
| Irregularities per min. |         |                |                 |

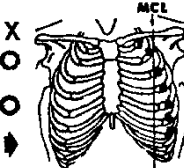
**13. Heart: is there any;**

|                                                                      |                                                                  |
|----------------------------------------------------------------------|------------------------------------------------------------------|
| Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No | Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No   | Edema <input type="checkbox"/> Yes <input type="checkbox"/> No   |

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

Location                       Indicate:

|                                         |  |                                                         |
|-----------------------------------------|--|---------------------------------------------------------|
| Constant <input type="checkbox"/>       |  | Apex by <input checked="" type="checkbox"/>             |
| Inconstant <input type="checkbox"/>     |  | Murmur area by <input type="checkbox"/>                 |
| Transmitted <input type="checkbox"/>    |  | Point of greatest intensity by <input type="checkbox"/> |
| Localized <input type="checkbox"/>      |  | Transmission by <input type="checkbox"/>                |
| Systolic <input type="checkbox"/>       |  |                                                         |
| Presystolic <input type="checkbox"/>    |  |                                                         |
| Diastolic <input type="checkbox"/>      |  |                                                         |
| Soft (Gr. 1-2) <input type="checkbox"/> |  |                                                         |
| Mod. (Gr. 3-4) <input type="checkbox"/> |  |                                                         |
| Loud (Gr. 5-6) <input type="checkbox"/> |  |                                                         |



After exercise:                      **Diagnosis:**

|                                    |  |  |
|------------------------------------|--|--|
| Increased <input type="checkbox"/> |  |  |
| Absent <input type="checkbox"/>    |  |  |
| Unchanged <input type="checkbox"/> |  |  |
| Decreased <input type="checkbox"/> |  |  |

**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"/> |

**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                      |

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)

- 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 GENTOURINARY DISEASE
  5. FAMILY HISTORY OF DIABETES

|                                                   |         |       |
|---------------------------------------------------|---------|-------|
| 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)

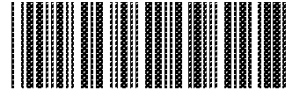
I certify that I made this examination at                       A.M.                       P.M. on the \_\_\_\_\_ day of \_\_\_\_\_ Date \_\_\_\_\_

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 87352, Chicago, IL 60689-0452  
 Administrative Office: P. O. Box 5086, Sioux Falls, SD 57117-5086  
 A Member of the Transamerica Financial Group



\*L2094\*

**NOTICE AND CONSENT FOR HIV-RELATED TESTING**

To evaluate your insurability, THE NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine 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 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 HIV-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

\_\_\_\_\_  
 Name of Proposed Insured

Address: \_\_\_\_\_  
 \_\_\_\_\_

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.

**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 will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please 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: \_\_\_\_\_

City/state/zip code: \_\_\_\_\_

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 the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

**Consent**

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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.

\_\_\_\_\_  
 Signature of Proposed Insured or Parent/Guardian

Date Signed: \_\_\_\_\_