



- 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 _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy) _____
------------------	-------------------	-----------------	--	----------------------------------

<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax ID No. <input type="checkbox"/> Exempt <input type="checkbox"/> 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 tested positive for the presence of HIV antibodies, antigens or the virus?.....  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 Mo.    Year	Recovery Mo.    Year	Doctors, Hospitals and Medical Facilities Info

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 \_\_\_\_\_



# Examiner's Report – Not Part of the Application

Agent Name \_\_\_\_\_

G.O. Code \_\_\_\_\_ Agent Code \_\_\_\_\_

9. **Blood Pressure.** Take a second reading at the end of the examination. Report all observations. (Do not complete if examinee is under age 12.)

1st reading                      2nd reading

Systolic      \_\_\_\_\_ mm. \_\_\_\_\_ mm.

Diastolic      \_\_\_\_\_ mm. \_\_\_\_\_ mm.

10. **Pulse.** (Do not report if examinee is under age 12.)

Pulse rate at rest \_\_\_\_\_ Per/Min.

Any pulse irregularity?       Yes     No

(If "Yes", obtain EKG and provide details below)

11. Did you measure the height of the examinee?       Yes     No  
If "No", provide details below.

12. Did you weigh the examinee?       Yes     No  
If "No", provide details below.

13. Did you observe any indication of physical or mental impairment not indicated on the medical form? (If "Yes", provide details below)       Yes     No

14. Are you related to the person examined or has the person ever consulted you for any reason other than an insurance examination? (If "Yes", provide details below)       Yes     No

15. Did the person examined communicate in English well enough to understand and answer the questions on the medical form?       Yes     No  
If no, who acted as interpreter?     Examiner     Agent     Other (Name and relationship to insured) \_\_\_\_\_

16. Urinalysis results (Do Not complete if examinee is under age 12)

Albumin \_\_\_\_\_     Sugar \_\_\_\_\_     Occult Blood \_\_\_\_\_

Do not send for further analysis unless there is a positive finding.

Is specimen being sent to the lab?     Yes     No

## COMPLETE THIS SECTION ONLY FOR A FULL MEDICAL EXAM.

### 17. Cardiovascular Examination.

a. Is there any evidence of cardiovascular disease excluding murmur? (If "Yes", provide details below)       Yes     No

b. Is a murmur present? (If "Yes", complete this section.)       Yes     No

Timing:       Systolic       Presystolic       Diastolic

Location:     Apex               Aortic               Pulmonic       Other \_\_\_\_\_

Transmission:  Axilla               Neck               Precordium     None               Other \_\_\_\_\_

Intensity:       Soft (Gr. 1-2)     Moderate (Gr. 3-4)     Loud (Gr. 5-6)

Impression: \_\_\_\_\_

### 18. Comments or Details to answers above:

Ques. No.	Comments or Details
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I CERTIFY that I have carefully examined the person named above and not in the presence of any other person except as stated in the comments section, that I have asked each question exactly as set forth on the reverse side of this sheet and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this and on the reverse side, and believe them to be correctly recorded, complete and true.

Please print your name \_\_\_\_\_ Signature \_\_\_\_\_

Name of examining company \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please stamp / provide Social Security No. or Tax ID No. and address.    SS # or TIN # \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**TO THE EXAMINER:** Any erasures or alterations in this report should be initialed by you. A copy of "answers to the Examiner" (other side of this form) is included in any policy issued; the "examiner's report" (this side of the form) is not included in the policy. If you have any information included above or not shown on this form which you believe should be seen only by Home Office Underwriting personnel, please send this report and any confidential information directly to Life Medical Underwriting, New York Life, 51 Madison Avenue, New York, NY 10010.