



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 Questionnaire (Non-Medical – 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 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		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 Proposed for Coverage _____
 Witnessed by _____
 Signature of Parent or Guardian, if Person Proposed for Coverage is under age 14 years and 6 months _____
 GO Code _____ Agent Code _____ Agent Last Name (Print) _____