



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 immune system disorder (including AIDS or AIDS Related Complex)?  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 \_\_\_\_\_

