☐ **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 tested positive on an Acquired Immune Deficiency Syndrome-related test? ☐ 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 ____________

M E D E X A M 0 2

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.