

Please print all answers.

Part 2 Application

1. Print Name of Proposed Insured

2. When were you last examined for insurance and for what company?

3. a. Name and address of your personal physician? (If none, say "none.")

b. Date and reason last consulted

c. What treatment was given or medication prescribed?

4. a. Proposed Insured's Family History

	Age	Living	Dead	
		State of Health	Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				

b. Did either parent, brother or sister ever have cancer, diabetes, or heart disease? (If "yes," give details.) Yes No

Check Applicable Items

5. Have you ever:

- a) received disability benefits, compensation or a pension? _____ Yes _____ No
- b) had high blood pressure or treatment thereof? _____ Yes _____ No
- c) had pain or other discomfort in the chest? _____ Yes _____ No
- d) had kidney stones, sugar, albumin or blood in the urine? _____ Yes _____ No
- e) once or more than once used cocaine, marijuana, barbiturates, narcotics, excitants, anabolic steroids, or hallucinogens except as medication prescribed by a physician? _____ Yes _____ No
- f) been treated or advised to seek treatment for drug abuse or alcoholism? _____ Yes _____ No
- g) been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immune Deficiency Syndrome)? _____ Yes _____ No

Details of "Yes" answers. Identify question number (include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.) Attach Form 6501 if an additional sheet of paper is necessary.

6. Have you ever had any of the following:

- a) heart murmur, palpitation, abnormal pulse or any other heart or circulatory trouble including varicose veins? _____ Yes _____ No
- b) nervous or mental trouble, convulsions, epilepsy, paralysis, dizzy or fainting spells, sick or severe headaches, psychological or psychiatric illness? _____ Yes _____ No
- c) asthma, bronchitis, emphysema, shortness of breath, pleurisy, tuberculosis or any other disorder of lungs? _____ Yes _____ No
- d) ulcers or any disorder of the stomach, liver, gallbladder, pancreas, intestines, appendix, or rectum including hemorrhoids and hernia? _____ Yes _____ No
- e) disorder of the kidneys, bladder, prostate or genito-urinary organs? _____ Yes _____ No
- f) cancer, tumor, cyst, syphilis, goiter or diabetes? _____ Yes _____ No
- g) gout, disorder of bone, joint, back, spine, arthritis, or any deformity? _____ Yes _____ No
- h) allergy or any disorder of the spleen or lymph glands? _____ Yes _____ No
- i) disorder of the skin, eyes, ears, nose, sinuses, throat or larynx? _____ Yes _____ No
- j) disorder of breasts or pelvic organs? _____ Yes _____ No

7. Have you within the past 5 years, other than noted above,

- a) had a check-up, consultation, illness, injury, or surgery? _____ Yes _____ No
- b) been a patient in a hospital, clinic or sanitarium? _____ Yes _____ No
- c) had an EKG, X-ray or other diagnostic tests? _____ Yes _____ No
- d) been advised to have any diagnostic test, hospitalization or surgery, which was not completed? _____ Yes _____ No

8. Have you within the past 12 months, _____

- a) smoked any cigarettes? _____ Yes _____ No
- b) used other forms of tobacco such as cigars, pipe or snuff? _____ Yes _____ No

9. Are you now under observation or taking treatment? _____ Yes _____ No

10. Has your weight changed more than 10 pounds in the past year?

If "yes," indicate the gain or loss, cause, and how long present weight maintained. _____ Yes _____ No

11. Are you pregnant? _____ Yes _____ No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

A copy of this application will be attached to and made part of the policy issued.

Dated _____ at _____ City _____ State _____

Witnessed by _____ (Medical Examiner)

Signature of Proposed Insured _____

Signature of Parent or Guardian if Proposed Insured is a minor _____

Authorization

To any physician, practitioner, hospital, clinic or other medical or medically-related facility, health care provider, insurance company or reinsurance company, insurance support organization, the Veterans Administration, MIB, Inc. (Medical Information Bureau), a consumer reporting agency, or employer:

In order to enable Ohio National Life to act upon my application for insurance or to decide if I qualify for benefits or coverage, I authorize you to give Ohio National Life (or to its legal representatives) any and all information, records or knowledge which you have about my physical or mental condition. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, and includes information about drugs, alcoholism or mental illness. You may also give Ohio National Life any financial, employment or personal information requested for insurance purposes.

Ohio National Life may release information to reinsurance companies, to MIB, Inc., or to others who perform business or legal services related to my application or the policy. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

- This authorization is good, as needed, for 24 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I understand that I have a right to receive a copy of this authorization.

Signature of Proposed Insured or Claimant _____

Date _____

Examiners Report

1a. Proposed Insured's name _____

1b. Date of birth _____

2. How did you identify the person to be examined?

Drivers License Other Picture I.D. (Describe): _____ Are you related? Yes No

3a. Height (in shoes)

_____ ft. _____ in.

3b. Weight (in clothes)

_____ lbs.

3c. Measurements

CHEST EXPANDED

_____ in.

CHEST CONTRACTED

_____ in.

WAIST

_____ in.

3d. Did you:

measure? Yes No

weigh? Yes No

4. Blood Pressure

SYSTOLIC

DIASTOLIC

	SYSTOLIC	DIASTOLIC
1ST READING		
2ND READING		
3RD READING		

If systolic reading is over 140 or diastolic over 90, submit three observations taken several minutes apart.

5. Pulse Rate

Regular

Irregular

3e. Is appearance unhealthy or older than stated age?

Yes No

6. Are there any abnormalities of the:	Yes	No
a. eyes, ears, nose, mouth, throat?		
b. skin (include scars), lymph nodes, varicose veins or peripheral arteries, edema?		
c. nervous system (include reflexes, gait, paralysis)?		
d. heart, cardiovascular system?		
e. respiratory system?		
f. abdomen (include hernias and scars)?		
g. genito-urinary system?		
h. endocrine system (include thyroid and breasts)?		
i. musculoskeletal system (include spine, joints, amputations, deformities)?		

Details of "yes" answers in questions 6 and 7.

7. Are you aware of additional medical history? Yes No
(a confidential report may be sent to the Medical Director.)

Examination was made at:

residence business my office

TIME

____:____ o'clock a.m. p.m.

DATE

MEDICAL EXAMINER _____

ADDRESS _____

Insurer: The Ohio National Life Insurance Company
 Ohio National Life Assurance Corporation
Address: P.O. Box 237, Cincinnati, Ohio 45201

Examiner: _____
Address: _____

Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

The HIV Antibody Test

To determine your insurability, the Insurer named above requests that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of Human Immunodeficiency Virus ("HIV") antibodies/antigens. A licensed laboratory will perform a series of tests by medically accepted procedures. By signing and dating this Notice, you agree that this HIV test may be done.

The HIV test is extremely accurate. However, like any medical test, the HIV test is not 100% accurate. In rare instances the HIV test may be positive in persons who are not infected with HIV. Additionally, the HIV test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous 3-6 months.

Meaning of HIV Test Results

Positive HIV test results do not mean that you have AIDS (Acquired Immunodeficiency Syndrome), but that you are at significantly increased risk of developing AIDS or AIDS-related conditions (ARC). Federal authorities say that persons who are HIV positive should be considered infected with the AIDS virus and capable of infecting others.

Negative HIV test results mean no antibodies/antigens were found. Because of varying incubation periods, absence of HIV antibodies/antigens does not mean that you have not been infected with HIV. Absence of HIV antibodies/antigens does not mean that you cannot get HIV in the future.

Counseling

Many public health organizations recommend that before taking an HIV 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. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or healthcare provider. A list of counseling resources is provided for your information at the end of this Notice.

Notification of Test Result

If your HIV test results are negative, no routine notification will be sent to you. If your results are other than negative, you are entitled to that information. Because a trained person should deliver positive HIV test results so that you clearly can understand what the test results mean, we ask that you provide the name of your physician so that he can tell you the HIV test results and explain its meaning.

Name of Physician: _____
Address: _____
City, State, and ZIP Code _____

Confidentiality of Test Results

All HIV test results are confidential. The laboratory will report them to the Insurer. The HIV 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 HIV test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The HIV test results 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.

Consent

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given printed material about HIV and AIDS. I voluntarily consent to the taking of a sample of my blood and/or other bodily fluids, the testing of that sample for HIV antibodies/antigens, and the disclosure of the HIV test results as described above. I understand that this Notice shall be valid for 2½ years from the date signed.

I understand that I have the right to request and receive a copy of this Notice, a photocopy of which will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian

Date

Print Name