

# Paramedical Supplement to Application

## Insurer

OM Financial Life Insurance Company

## Insured

First Name

Middle Initial

Last Name

Birth Date

Birth Place

## Medical History Questions

1. Have you ever been treated for or diagnosed with:

a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?	<input type="radio"/> Y <input type="radio"/> N
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?	<input type="radio"/> Y <input type="radio"/> N
c) Any breathing or lung disorder, COPD, asthma, bronchitis, sleep apnea, or emphysema?	<input type="radio"/> Y <input type="radio"/> N
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	<input type="radio"/> Y <input type="radio"/> N
e) Cancer, tumor, or cysts?	<input type="radio"/> Y <input type="radio"/> N
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	<input type="radio"/> Y <input type="radio"/> N
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?	<input type="radio"/> Y <input type="radio"/> N
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	<input type="radio"/> Y <input type="radio"/> N
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?	<input type="radio"/> Y <input type="radio"/> N
j) Any disease or disorder of the skin, eyes, or ears?	<input type="radio"/> Y <input type="radio"/> N
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or positive test results indicating the presence of the AIDS virus?	<input type="radio"/> Y <input type="radio"/> N
2. Are you currently prescribed any medication?	<input type="radio"/> Y <input type="radio"/> N
3. Have you been prescribed medication in the past 5 years not previously mentioned?	<input type="radio"/> Y <input type="radio"/> N
4. In the past 10 years, have you:	
a) Been hospitalized or had surgery?	<input type="radio"/> Y <input type="radio"/> N
b) Had any electrocardiograms, x-rays, laboratory tests, treatment, or surgery, or been advised to and not done so?	<input type="radio"/> Y <input type="radio"/> N
c) Been recommended to have any test, treatment, or surgery, which has not been performed?	<input type="radio"/> Y <input type="radio"/> N
d) Had any illness, disease, or injury that is not included in other answers?	<input type="radio"/> Y <input type="radio"/> N
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?	<input type="radio"/> Y <input type="radio"/> N
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine-based products such as the patch, or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.	<input type="radio"/> Y <input type="radio"/> N
7. In the past 10 years, have you sought or received treatment, advice, or counseling for the use of alcohol?	<input type="radio"/> Y <input type="radio"/> N
8. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?	<input type="radio"/> Y <input type="radio"/> N
9. Within the past 10 years, have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	<input type="radio"/> Y <input type="radio"/> N

CONTINUED



**Paramedical Supplement to Application – Continued**

**Medical Examiner's Report**

12. a.	Height (in shoes)	Weight (Clothed)	Males Only:		
	ft.      in.	lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.
	b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	c. Is appearance unhealthy or older than state age? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13.	Blood Pressure:	1 <sup>st</sup> Reading	2 <sup>nd</sup> Reading	3 <sup>rd</sup> Reading	
	Systolic				
	Diastolic 5 <sup>th</sup> Phase				
14.	Pulse:	At Rest	After Exercise	3 Minutes Later	
	Rate				
	Irregularities per min. (Answer all columns)				
15.	Heart: Is there any:				
	Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Murmur(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<u>Murmur 1</u> <u>Murmur 2</u>	Indicate:		
	Murmur Location		Apex by		
	Transmitted	<input type="checkbox"/> <input type="checkbox"/>	Murmur area by		
	Localized	<input type="checkbox"/> <input type="checkbox"/>	Point of greatest intensity by		
	Constant	<input type="checkbox"/> <input type="checkbox"/>	Transmission by		
	Inconstant	<input type="checkbox"/> <input type="checkbox"/>	In your opinion is murmur organic or functional? _____		
	Systolic	<input type="checkbox"/> <input type="checkbox"/>	If organic, your diagnosis. _____		
Diastolic	<input type="checkbox"/> <input type="checkbox"/>				
Presystolic	<input type="checkbox"/> <input type="checkbox"/>				
Soft (Gr. 1-2)	<input type="checkbox"/> <input type="checkbox"/>				
Mod. (Gr. 3-4)	<input type="checkbox"/> <input type="checkbox"/>				
Loud (Gr. 5-6)	<input type="checkbox"/> <input type="checkbox"/>				
After exercise:					
Increased	<input type="checkbox"/> <input type="checkbox"/>				
Unchanged	<input type="checkbox"/> <input type="checkbox"/>				
Decreased	<input type="checkbox"/> <input type="checkbox"/>				

Record any additional information here: it will be considered strictly confidential. Anything regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated.

16. Is there on examination any abnormality of the following: *(Circle applicable item and give details.)*

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? .....	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If vision or hearing is markedly impaired, indicate degree and correction.)</i>		
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (include prostate)? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include spine, joints, amputation, deformities)?.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

17. a. Are there any hernias?     Yes     No      b. Any hemorrhoids?.....    

18. Are you aware of additional medical history? .....

*(A confidential report may be sent to the Medical Director)*

Name of person who requested you to make this examination: \_\_\_\_\_

Place examined:  Your Office     Proposed Insured's:     Home or     Office

Date examined: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature of Medical Examiner \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**HOME OFFICE USE ONLY:** Fee Paid \$ \_\_\_\_\_

# Notice and Consent Form for AIDS Virus (HIV) Antibody / Antigen Testing

## INSURER

OM Financial Life Insurance Company

## EXAMINER

Name and Address

Acquired Immunodeficiency Virus (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, urine or oral fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department.

If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or event that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification letter will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

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

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

\_\_\_\_\_ Address: \_\_\_\_\_  
Name

I have read and understood this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

<b>Name of Proposed Insured</b>	<b>Date of Birth</b>	<b>State of Residence</b>
<b>Signature of Proposed Insured or Parent/Guardian</b>		<b>Date</b>