



APPLICATION FOR INSURANCE - PART II

Old Republic Life Insurance Company
307 North Michigan Avenue, Chicago, IL 60601

Proposed Insured: _____ Date of Birth: _____

Name and Address of your Primary Physician: _____

Date last seen: _____ Reason, Medication or treatment given: _____

Your Height: _____ ft./in. Your Weight: _____ lbs. Have you lost weight in the past year? Yes _____ lbs. No

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have you been diagnosed as having or been treated by a physician for: | | |
| a. Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, seizures, convulsions, headache, paralysis, stroke, mental or nervous disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema, chronic respiratory disorder or allergies?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, heart attack, heart murmur, palpitations, high blood pressure, high cholesterol, or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hepatitis, jaundice, ulcer, colitis, diverticulitis or other disorder of the stomach, intestines, liver or gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in the urine, stones or other disorder of the kidney, prostate or bladder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, thyroid or other endocrine disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Severe injuries or any disease or disorder of the muscles, bones or joints, including arthritis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cancer, tumor, cyst, disease of the lymph glands, breasts or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Anemia or other non-HIV disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Alcohol or drug use? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Fatigue, malaise, loss of appetite, weight loss, diarrhea, fever or night sweats? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other than above, have you, within the past 5 years: | | |
| a. Had any mental or physical disorder not listed above?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had any checkup, illness, injury or surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanitarium, chemical dependency program, treatment center, halfway house or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had an electrocardiogram, x-ray or other diagnostic test (except HIV tests)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have a diagnostic test (except HIV tests), hospitalization or surgery which has not been completed? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Used illegal drugs such as cocaine, heroin, narcotics, amphetamines, barbiturates, hallucinogens or marijuana? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| Other than as already disclosed, are you currently taking any medication or are you now being treated for any condition? | <input type="checkbox"/> | <input type="checkbox"/> |

4. Have you, within the past 5 years, used any form of tobacco or nicotine product, including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum?
- (If Yes, give type, frequency and date of last usage)
5. Has any natural parent or sibling had cancer, diabetes, heart or circulatory disease, kidney disease or mental illness?.....
- | 6. Family History | Age if Living | Cause of Death | Age at Death |
|----------------------|---------------|----------------|--------------|
| Father: | | | |
| Mother: | | | |
| Brothers and Sisters | | | |
| No. Living: _____ | | | |
| No. Dead: _____ | | | |

Provide Details of all YES answers. Show question being answered, dates, duration, medication and the name and address of all physicians or medical facilities.

If additional space is needed, attach a separate page

I declare that the statements and answers given in this form are true and complete to the best of my knowledge and belief. I understand that these statements and answers shall form a part of my application for this policy and will be relied upon by Old Republic Life Insurance Company in approving any coverage.

Date: _____ City & State: _____

Signature: _____ Witness: _____

Signature of the proposed insured

Signature of witness or examiner

Note: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files an application, statement or claim containing any false, incomplete or misleading information may be guilty of insurance fraud. Not applicable to applications taken in Virginia.



EXAMINER'S REPORT - PART III

Old Republic Life Insurance Company
307 North Michigan Avenue, Chicago, IL 60601

Proposed Insured: _____ Date of Birth: _____

QUESTIONS 1 THROUGH 6 ARE FOR ALL EXAMINERS

1. What Photo Identification did you use to identify the Proposed Insured? Driver's License: _____
 Other: _____
2. Location of examination: Examiner's Office Applicants residence
 Applicants work site Other: _____
3. Did the applicant sign and receive a copy of the Notice and Consent for Testing? Yes No (If No, why not?)
4. Height (in shoes): _____ ft./in. Weight (clothed): _____ lbs.
5. Blood Pressure: 1st _____ 2nd _____ 3rd _____
If first reading is above 140/90 or if there is a history of hypertension, obtain two additional readings.
6. Measurements (males only)
Chest (full inspiration) _____ in. Chest (full expiration) _____ in. Abdomen (at umbilicus) _____ in.

QUESTIONS 7 AND 8 ARE FOR M. D. EXAMINERS ONLY

<p>7. In examining the Proposed Insured, do you find any abnormality of the following:</p> <ol style="list-style-type: none"> a. Eyes, ears, nose, mouth, pharynx? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If vision or hearing is impaired indicate degree and correction)</i> b. Skin (including scars), lymph nodes, varicose veins, or peripheral arteries? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Nervous system (reflexes, gait, and paralysis)? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Abdomen (including scars)? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Genitourinary system? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Endocrine system (including thyroid & breasts)? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Musculoskeletal system (including spine, joints, amputations and deformities)? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Is the liver enlarged? <input type="checkbox"/> Yes <input type="checkbox"/> No j. Heart and blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If there is a history of heart murmur or rheumatic fever or if you find any abnormality in heart rhythm, sound or size, complete question 8.)</i> k. Are you aware of any additional medical history or symptoms not brought out by the foregoing questions? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>8. To be completed if question 7j is Yes.</p> <ol style="list-style-type: none"> a. Any evidence of cardiac enlargement or abnormal heart sounds? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Are there any murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, describe)</i> c. Are there any gallops (If Yes, describe) <input type="checkbox"/> Yes <input type="checkbox"/> No 	<p style="text-align: center;"><i>Comments and details of all Yes answers</i></p>
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Indicate items you completed: Blood and urine samples sent to: Osborn Labs Other lab (explain)
 Resting EKG (mounted without interpretation) Treadmill EKG (without interpretation)
 Other: _____

Name of Examiner/Company: _____ Date: _____

Name of Agent/Agency who ordered this exam: _____

COMPLETED EXAMINATION FORMS ARE TO BE FORWARDED WITH THE BLOOD & URINE SAMPLES DIRECTLY TO OSBORN LABS.

(In those cases where no blood or urine sample is obtained, forward the completed examination to the Home Office at the address below)

Old Republic Life Insurance Company - P.O. Box 8548, Chicago, IL 60680-8548 Phone: (800) 621-0365



HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT

Acquired Immunodeficiency (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS includes males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free from symptoms for years after becoming infected. Symptoms of AIDS may include fever including "night sweats", unexplained or sudden weight loss, extreme fatigue or tiredness, recurring diarrhea, swollen lymph glands in the neck, underarm or groin area, white spots or unusual blemishes in the mouth and severe pneumonia.

An AIDS - related virus (HIV) antibody test detects antibodies to the AIDS virus that causes the disease. The purpose of the test is to determine whether you may have been infected with HIV. This test is not a test for AIDS; AIDS can only be diagnosed by a medical evaluation. The test will be performed according to the following medical protocol:

1. An initial ELISA blood test will be done.
 - a. If the initial ELISA blood test is positive, it will be repeated.
 - b. If the initial ELISA blood test is negative, a negative finding will be reported to the Company.
2. If the initial ELISA blood test is positive, it will be repeated.
 - a. If the second ELISA blood test is also positive, a Western Blot blood test will be performed to confirm the positive results of the two ELISA tests.
 - b. If the second ELISA blood test is negative, a third ELISA blood test will be performed. If the third ELISA blood test is positive, a Western Blot blood test will be performed to confirm the previous positive results. If the third ELISA blood test is negative, a negative result will be reported to the Company.
3. Only if at least two ELISA blood tests and a Western Blot blood test are positive will the result be reported as positive. All other results will be reported as negative to the Company.

The HIV antibody test is extremely accurate. However, the test is not without error. Possible errors include a false positive, this may occur even though you are not infected and the test gives a positive result. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test. False negatives, another possible error, occurs when the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

A positive test result may cause you significant anxiety. A negative test may create a false sense of security. Public health authorities urge everyone to become educated about how to protect themselves from HIV infection. If you have any questions about AIDS or the HIV antibody tests, you should contact your physician or one of the AIDS counseling resources on the Reverse Side.



Old Republic Life Insurance Company

307 North Michigan Avenue, Chicago, IL 60601

California

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

To evaluate your eligibility for insurance or insurance benefits, it is requested that you consent to be tested for AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could 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.

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as allowed by law or as authorized by you.

The insurer will notify you if your test results are positive or if your results cannot be accurately determined. If you so authorize, the company will also send your results to a physician or other person or other health care provider with whom you may want to discuss the results.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician, person, or entity:

Name: _____

Address: _____

I have read and understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Printed name of Proposed Insured

Date

Signature of Proposed Insured

Signature of Witness