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MEDICAL EXAM FOR LIFE INSURANCE PART II

This application is to be attached to and made part of the policy.

PROPOSED INSURED INFORMATION (please print)

1. First name _____ MI _____ Last name _____
 Date of birth (mm/dd/yyyy) _____
 Name and address of your personal physician. If you don't have a personal physician, write "none."

 Date and reason last consulted _____
 What treatment or medication was given or recommended? _____
 Weight change past year Gain Loss _____ lbs.
 Reason for change _____

If you answer "yes" to any of the questions 2-12, provide details in item 13 on the next page.

2. Have you had, been treated for, or received a consultation or counseling for:

- a. cancer or a tumor? Yes No
- b. high blood pressure, chest pain, or disorder of the heart or circulatory system? Yes No
- c. diabetes or disorder of the glands, bone, blood, or skin? Yes No
- d. complications of pregnancy, infertility, any disorder of the breasts or reproductive organs, prostate, kidneys, or urinary system? Yes No
- e. hernia; hepatitis; or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines, or rectum? Yes No
- f. arthritis; rheumatism; or disorder of the joints, limbs, or muscles? Yes No
- g. disorder or condition of the back, neck, or spine? Yes No
- h. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? Yes No
- i. epilepsy, stroke, dizziness, headache, or disorder of the brain or spinal cord? Yes No
- j. disorder of the eyes, ears, nose, or throat? Yes No
- k. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? Yes No
- l. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus, or Lyme Disease? Yes No

3. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment, or handicap? Yes No

4. Have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus (HIV)? Yes No

5. a. Are you currently taking prescribed medication? Yes No
 b. Are you currently taking non-prescription medication? Yes No

6. a. Have you ever used stimulants, hallucinogens, narcotics, or any other controlled substance? ... Yes No
 b. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? ... Yes No
If "yes," complete the Alcohol and Drug Usage Supplement.

7. Are you now pregnant? Yes No
If "yes," expected delivery date _____

8. Within the past five years, have you had a physical exam or checkup of any kind? Yes No

MEDICAL EXAM FOR LIFE INSURANCE PART II

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

1. How long have you known the Proposed Insured?
 a. Has the Proposed Insured ever been your patient? Yes No
 If "yes," are details included in history given?
 b. Are you related to the Proposed Insured or Agent? Yes No
 c. Are you examining the Proposed Insured concurrently for another company? Yes No

2. **BUILD**

		MALES ONLY		
a. Height (in shoes) ft.	Weight (Clothed) lbs.	Chest Full Inspiration in.	Chest Forced Expiration in.	Abdomen or 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		

3. **PULSE**

	Rate	Number of Irregularities
At rest		
Immediately after exercise		
Two minutes after exercise		

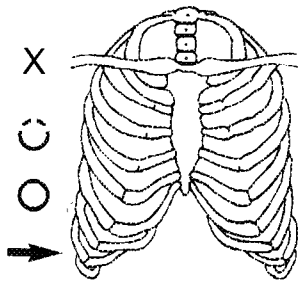
4. **BLOOD PRESSURE** (If above 140/90, record additional readings.)

Systolic			
Diastolic 5th Phase			

5. **HEART**

Is there any: Enlargement? Yes No Dyspnea? Yes No
 Murmur(s)? Yes No Edema? Yes No
 (Describe below--If more than one, describe separately.)

	First Murmur	Second Murmur	
Location	<input type="checkbox"/>	<input type="checkbox"/>	Indicate
Constant	<input type="checkbox"/>	<input type="checkbox"/>	
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Apex by
Localized	<input type="checkbox"/>	<input type="checkbox"/>	
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	by point of
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	greatest
Soft (GR. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>	intensity by
Mod. (GR. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	
Loud (GR. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by
After Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	
Increased	<input type="checkbox"/>	<input type="checkbox"/>	Your comments
Absent	<input type="checkbox"/>	<input type="checkbox"/>	and impressions:
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased	<input type="checkbox"/>	<input type="checkbox"/>	



6. Do you find evidence of past or present abnormality of:
 a. eyes, ears, nose, or throat? (If appreciable change, give measured eye impairment or hearing loss.) Yes No
 b. skin, breasts, lymph nodes, thyroid, or other endocrine glands? Yes No
 c. lungs, pleura, or respiratory tract? Yes No
 d. abdomen or abdominal viscera? Yes No
 e. kidneys or genitourinary tract? Yes No
 f. brain or nervous system? (Include any tremor or abnormal reflexes.) Yes No
 e. musculoskeletal system? (Describe deformities or limitation.) Yes No

7. Is a hernia present? (If "yes," describe below.) Yes No

8. **BLOOD VESSELS**

a. Any evidence of arteriosclerosis? Yes No
 b. Any varicosities? Yes No

DETAILS OR REMARKS

LAB TESTING IS REQUIRED. USE PROPER KIT AND SEND TO THE LAB.

I certify that I have carefully examined _____ whose signature is affixed to the foregoing declarations and that examination was made in private at: my office residence of Proposed Insured
 agency office place of business of Proposed Insured
 other

on this _____ day of _____, _____ at _____ a.m. p.m.

This examination is for: Life Insurance Disability Insurance Other Purposes _____

Signed _____
MEDICAL EXAMINER

Examiner, please give name of agent/broker or agency requesting this examination: _____

AGENT/BROKER _____ ADDRESS _____

If not appointed examiner for the Company, please complete information below:
 State in which licensed: _____ Date of license: _____ License number: _____

THIS REPORT MUST BEAR DATE EXAMINATION ACTUALLY MADE AND UNDER NO CIRCUMSTANCES ANY OTHER