

- The Penn Mutual Life Insurance Company**
Philadelphia, PA 19172
- The Penn Insurance and Annuity Company**
Philadelphia, PA 19172

Application for Life Insurance - Part II
Medical Examiner's Report

Proposed Insured _____ Date of Birth _____

1. Give full name and address of your personal physician. If no personal physician, give full name and address of last physician consulted. (Include dates and reasons why either was consulted.)				
2. Have you ever been treated for or had any indication of:	Yes	No	INSTRUCTIONS: Give details for all "Yes" answers. (IDENTIFY QUESTION NUMBERS. CIRCLE APPLICABLE ITEMS. Give the diagnoses, dates, treatment, duration of illness and names and addresses of all attending physicians and medical facilities.)	
(a) Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>		
(b) Epilepsy, fainting, convulsions, frequent headaches; paralysis or stroke; mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
(c) Shortness of breath, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
(d) Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>		
(e) Jaundice, intestinal bleeding, ulcer, hernia, colitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>		
(f) Sugar or albumin in urine; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?	<input type="checkbox"/>	<input type="checkbox"/>		
(g) Diabetes; thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
(h) Arthritis, gout, or disorder of muscles, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>		
(i) Deformity, lameness or amputation?	<input type="checkbox"/>	<input type="checkbox"/>		
(j) Disorder of skin, lymph glands; cyst, tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
(k) Allergies; anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Have you ever:				
(a) Habitually used amphetamines, barbituates, hallucinogens, marijuana or narcotics?	<input type="checkbox"/>	<input type="checkbox"/>		
(b) Been counselled or treated for the excessive use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Have you within the past 5 years:				
(a) Had a checkup or physical examination?	<input type="checkbox"/>	<input type="checkbox"/>		
(b) Been a patient in a hospital or other medical facility or had any type of surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
(c) Had an electrocardiogram or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>		
(d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>		
(e) Had any disease or injury not listed above?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Are you presently under medical observation or taking any medication?				
			<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?				
			<input type="checkbox"/>	<input type="checkbox"/>
7. Any family history of diabetes or heart disease?				
			<input type="checkbox"/>	<input type="checkbox"/>
8. Family history	Age if living	State of health	Age at death	Cause of death
Father				
Mother				
Brothers and Sisters				
No. living <input style="width: 40px;" type="text"/>				
No. dead <input style="width: 40px;" type="text"/>				

I represent that the statements and answers in this Part II are written as made by me and are full, complete and true to the best of my knowledge and belief. I agree that they will be a part of the contract of insurance if issued, that I will be bound by such statements and answers, and that Penn Mutual/Penn Insurance and Annuity Company, believing them to be true, will rely and act upon them.

Signed on _____ 19 _____, at _____, State of _____

Witness _____
Medical Examiner
Signature of Proposed Insured

1. (a) Height (In shoes) <input style="width: 40px; height: 20px;" type="text"/> ft. <input style="width: 40px; height: 20px;" type="text"/> in. (b) Weight (Clothed) <input style="width: 40px; height: 20px;" type="text"/> lbs.	Males Only	Details of "Yes" answers. (<i>Identify and circle applicable items.</i>)			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Chest (Full inspiration) <input style="width: 40px; height: 20px;" type="text"/> in.</td> <td style="width: 33%; text-align: center;">Chest (Forced expiration) <input style="width: 40px; height: 20px;" type="text"/> in.</td> <td style="width: 33%; text-align: center;">Abdomen at Umbilicus <input style="width: 40px; height: 20px;" type="text"/> in.</td> </tr> </table>		Chest (Full inspiration) <input style="width: 40px; height: 20px;" type="text"/> in.	Chest (Forced expiration) <input style="width: 40px; height: 20px;" type="text"/> in.	Abdomen at Umbilicus <input style="width: 40px; height: 20px;" type="text"/> in.
Chest (Full inspiration) <input style="width: 40px; height: 20px;" type="text"/> in.	Chest (Forced expiration) <input style="width: 40px; height: 20px;" type="text"/> in.		Abdomen at Umbilicus <input style="width: 40px; height: 20px;" type="text"/> in.		
(c) Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No (d) Any weight change in past year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. Blood Pressure (Record only resting readings)					
Systolic <input style="width: 40px; height: 20px;" type="text"/>					
Diastolic (5th phase) <input style="width: 40px; height: 20px;" type="text"/>					
Time of day _____ A.M. _____ P.M.					
3. Pulse					
	At rest	After exercise <small>(25 hops each foot)</small>			
Rate	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>			
Irregularities per minute	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>			
4. Heart: Is there any: Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Describe whether systolic or diastolic, constant or inconstant, location, grade, transmission and effect of exercise. Give your comments and impression. If more than one murmur, describe separately.)</i>					
5. On examination, is there any abnormality of the following:					
	Yes	No			
(a) Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>			
(b) Skin; 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?	<input type="checkbox"/>	<input type="checkbox"/>			
(f) Genito-urinary system?	<input type="checkbox"/>	<input type="checkbox"/>			
(g) Endocrine system?	<input type="checkbox"/>	<input type="checkbox"/>			
(h) Musculoskeletal system?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Urinalysis					
	Specific Gravity	Albumin			
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>			
Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No					
SEND SPECIMEN TO LAB IF: (a) Albumin or sugar present or blood pressure over 140/90. (b) History of Hypertension, Diabetes or Genito-urinary disorder. (c) Requested by agency.					
7. Are you aware of any additional factors which might influence insurability? <input type="checkbox"/> Yes <input type="checkbox"/> No (A separate report may be sent to Medical Director)					
Name of general agent or regional director _____ 3 digit office code _____					
Name of examiner _____		Name of agent _____			
Address of examiner _____		Date of examination _____ at _____			
<input type="checkbox"/> Examiner's office <input type="checkbox"/> Other _____					

AUTHORIZATION

I authorize any physician, medical professional, hospital, clinic or other medically related facility or insurance company to disclose to The Penn Mutual/Penn Insurance and Annuity and its reinsurers any of the following pertaining to me or my children, if they are to be insured: information relating to my physical and mental condition; medical care, advice or treatment; and avocation, insurance, aviation, criminal activity and driving record. This information will be used by Penn Mutual/Penn Insurance and Annuity and its reinsurers to determine eligibility for insurance.

To facilitate rapid transmission of such information, I authorize all such sources to give such records or information to any insurance support organization authorized by Penn Mutual/Penn Insurance and Annuity to collect and transmit such information.

I understand that this authorization will be valid for two and one half years from the date shown below.

Signed on _____, 19____

(Signature of Proposed Insured)
 (Parent if Proposed Insured is age 15 or less)

at _____, State of _____