

MEDICAL QUESTIONS

Full name of person proposed for insurance: _____ Date of Birth (Month/Day/Year): _____

Name, address and telephone number of your personal physician? (If none check box) None _____

Date and reason last consulted? _____

What treatment was given or medication prescribed? _____

MEDICAL QUESTIONS - Each question must be individually asked and answered.

To the best of your knowledge, has any Proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for: *

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1) Illness, injury or disease of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | 11) Any illness or disease of the male or female reproductive organs, sexually transmitted disease, prostate problems, irregular menstruation or abnormal pap test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Epilepsy, seizures, chronic headaches, head injury, paralysis, or other disorder of the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> | 12) An examination, treatment or consultation with a doctor or health care provider other than above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Anxiety, depression, affective disorder, eating disorder, psychotic disorder, or other psychiatric treatment? | <input type="checkbox"/> | <input type="checkbox"/> | 13) Had or been advised to have a check-up, consultation, lab test, EKG, x-ray, or other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Asthma, emphysema, tuberculosis, shortness of breath, persistent hoarseness or cough, or other respiratory illness or disease? | <input type="checkbox"/> | <input type="checkbox"/> | 14) Received or been advised to have treatment for drug usage, whether legal or illegal, alcoholism or been a member of AA? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) High blood pressure, heart attack, stroke, heart murmur, palpitation, arrhythmia, chest pain, rheumatic fever, or other illness or disease of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> | 15) Are you currently under the observation of a physician or taking medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Ulcer, colitis, Crohn's disease, diverticulitis, hepatitis, intestinal bleeding, or illness or disease of the gallbladder, stomach, intestines, or liver? | <input type="checkbox"/> | <input type="checkbox"/> | 16) Family History: Is there a history of cardiovascular disease or cancer in parent/siblings prior to age 60? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system? | <input type="checkbox"/> | <input type="checkbox"/> | 17) Do you participate in a regular, supervised exercise program or other organized sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Diabetes, thyroid disorder, cholesterol elevation, anemia, or other illness or disease of the blood? | <input type="checkbox"/> | <input type="checkbox"/> | 18) Do you know of any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure, Diabetes, or committed suicide? (Please show age at onset and/or date of death). | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Arthritis, gout, lupus, illness, injury or disease of the back, spine or joints, or other illness, injury or disease of the muscles, bones or skin? | <input type="checkbox"/> | <input type="checkbox"/> | 19) Have you had any weight change in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Cysts, tumor, skin cancer or any other cancer or malignancy? | <input type="checkbox"/> | <input type="checkbox"/> | 20) Have you or any Proposed Insured EVER, had or been told you/they have AIDS, or AIDS Related Complex (ARC), or been tested for HIV antibodies for the purpose of obtaining insurance? | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY

	Age if Living?	Status of Health	Age of Death?	Cause of Death?
Father				
Mother				

Give details regarding "yes" answers number 1-20 (Please print)

Question No.	Disease, symptom, injury, etc.	Dates	Duration	No. of Attacks	Name and Address of Attending Physicians and Hospitals

I represent that I have read and understand all the statements and answers herein and in Part 1 of my application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded whether written in my own hand or not. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. I agree that this application and any policy or policies issued based on this application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgement and ratification of any corrections made in the application; except, that no change in amount of insurance, age at issue, classification, kinds of insurance or benefits will be made unless agreed in writing by the applicant.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, to give to the PBL Life Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

Date _____ Signature of Proposed Insured _____

Examiner _____ Signature of Parent if insured is a minor _____

Insurer _____

Address _____

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

The HIV Antibody Test: To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A series of tests may be performed by a licensed laboratory through a medically accepted procedure. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the 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 Test Results: Positive HIV antibody/antigen test results do not mean that you have AIDS, but 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. A positive HIV antibody test result will probably mean you will be declined for the insurance for which you are applying.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Counseling: Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider 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 own physician or own health care provider. A list of counseling resources is provided for your information.

Notification of Test Results: If your test results are negative, no routine notification will be sent to you. If your test results are other than negative you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your own, private physician so that the insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal and Confidential", at your residence address.

Name of Physician: _____

Address: _____

Confidentiality of Test Results: All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The 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 or claims 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. Negative test results may be disclosed to a reinsurer.

If the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures 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 specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 ½ years from the date shown below.

Insurer _____

Address _____

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

The HIV Antibody Test: To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A series of tests may be performed by a licensed laboratory through a medically accepted procedure. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the 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.

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A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Counseling: Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider 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 own physician or own health care provider. A list of counseling resources is provided for your information.

Notification of Test Results: If your test results are negative, no routine notification will be sent to you. If your test results are other than negative you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your own, private physician so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal and Confidential", at your residence address.

Name of Physician: _____

Address: _____

Confidentiality of Test Results: All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The 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 or claims 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. Negative test results may be disclosed to a reinsurer.

If the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures 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 specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 ½ years from the date shown below.

CONSENT: I have read and understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written materials about AIDS. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and 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.

Name of Proposed Insured

Date

Signature of Proposed Insured