

**PHYSICIANS LIFE INSURANCE COMPANY**  
 2600 Dodge Street  
 Omaha, NE 68131-2671

**MEDICAL EXAMINATION  
 SUPPLEMENTAL APPLICATION**

Name of Proposed Insured (Please Print)	Birthdate			Sex	Print Name and Address of Personal Physician:
	Mo.	Day	Yr.		

<b>MEDICAL HISTORY (to be recorded by medical examiner):</b>		<b>YES</b>	<b>NO</b>	
1.	Within the past five years, have you taken or been advised to take any medication prescribed by a physician? Please list current medications. ....	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Have you ever been treated or diagnosed by a medical professional as having a disorder or disease of, but not limited to: .....			Date last seen:
	a. <b>Respiratory System</b> (lungs, bronchi, trachea) such as TB, asthma, emphysema, bronchitis, shortness of breath, persistent cough, pneumonia? .....	<input type="checkbox"/>	<input type="checkbox"/>	Reason:
	b. <b>Circulatory System</b> (heart, blood, arteries, veins) such as high blood pressure, heart attack, heart disease, murmur, rheumatic fever, anemia, hemophilia? .....	<input type="checkbox"/>	<input type="checkbox"/>	Outcome:
	c. <b>Digestive System</b> (esophagus, stomach, intestine, liver) such as ulcer, cirrhosis, hepatitis, colitis, gastrointestinal bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE GIVE FULL DETAILS FOR ANY "YES" ANSWERS  List diagnosis, dates, duration, number of days hospitalized, treatment, results; and names, addresses, and phone numbers of all attending physicians and medical facilities.
	d. <b>Nervous System</b> (brain, nerves) such as dizziness, paralysis, multiple sclerosis, fainting, epilepsy, convulsions, seizures, stroke, dementia, Alzheimer's, anxiety, depression, chronic fatigue, or other mental or nervous disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	e. <b>Muscular and Skeletal</b> (muscles, bones, joints, spine) such as neck or back problems, fracture, arthritis? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	f. <b>Genitourinary System</b> (kidney, bladder, reproductive organs, abnormal pap smears) such as infection, bleeding, albumin, or blood or pus in urine? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	g. <b>Endocrine/Lymphatic System</b> (thyroid, pancreas, adrenal, lymph glands) such as diabetes, abnormal growth or function, or swollen glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Have you ever been told you have or been treated for Aquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Have you ever had cancer, tumor or abnormal growth; chest pains; sexually transmitted disease; skin disease; prolonged or recurrent infections; leukemia or Hodgkin's disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Have you lost or gained weight during the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	If yes, Gain _____ lbs. Loss _____ lbs. Reason?			
6.	Within the past 10 years, have you consulted a medical professional for or had treatment for alcohol or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Other than above, within the past 10 years, have you: .....			
	a. Consulted, been examined or been treated by, any physician or practitioner or been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Had an electrocardiogram, x-ray, MRI, CAT Scan, any blood test or other laboratory tests? .....	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Do or did any of your natural family members (mother, father, sibling) have a history of diabetes, cancer, heart trouble, or stroke? If yes, please explain below. ....	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/>
				No <input type="checkbox"/>

Family Member	Condition				Age of Onset	Age, if Living	State of Health	Age at Death	Cause of Death
	Diabetes	Cancer	Heart Disease	Stroke					
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Siblings (list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

It is agreed and understood that:  
 (1) The statements and answers in this application and any attached supplements are true, complete and correctly recorded to the best of my knowledge and belief and will be the basis for issue of the policy; (2) The policy, this application and any attachments will constitute the Entire Contract of insurance; (3) No Agent has the authority to alter the Company's rules or requirements, this Agreement, the Conditional Receipt, or the policy; (4) Except as provided in any duly issued Conditional Receipt, the policy does not become effective until, during the lifetime of the Proposed Insured: (a) the first full premium is paid; (b) the policy is issued, delivered and accepted by the Owner; and (c) any amendments issued with the policy are completed and signed, as required; all while the Proposed Insured's health and habits remain as stated in the application and attached supplements.

_____ Signature of Medical Examiner	_____ Signature of Proposed Insured	_____ Date
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**Physicians Life Insurance Company  
2600 Dodge Street, Omaha, NE 68131**

**CONFIDENTIAL MEDICAL EXAMINER'S REPORT**

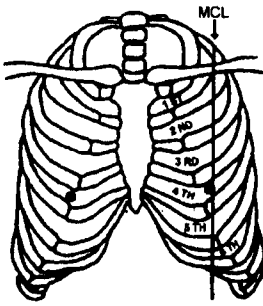
1. a. Height _____ ft. _____ in. Weight _____ lbs. b. Did you weigh and measure applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chest (Full Inspiration) _____ in.	Chest (Forced Expiration) _____ in.	Abdomen, at Umbilicus _____ in.	Applicant's Identity was established by: <input type="checkbox"/> Driver's License # _____ <input type="checkbox"/> Social Security # _____ <input type="checkbox"/> Other _____											
2. Blood Pressure (Record all readings) (If Above 140/90 Record Additional Readings.) <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:20%; text-align: center;">1st</td> <td style="width:20%; text-align: center;">2nd</td> <td style="width:20%; text-align: center;">3rd</td> </tr> <tr> <td style="text-align: center;">Systolic</td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Diastolic (5th phase)</td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> </tr> </table>					1st	2nd	3rd	Systolic				Diastolic (5th phase)			
	1st	2nd	3rd												
Systolic															
Diastolic (5th phase)															

3. Pulse:  Rate _____ Irregularities per min. _____	Exercise if irregular, over 90 or less than 50 per min. <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align: center;">At Rest</td> <td style="width:33%; text-align: center;">After Exercise</td> <td style="width:33%; text-align: center;">3 Minutes Later</td> </tr> <tr> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> <td style="border: 1px solid black; width: 50px; height: 20px;"></td> </tr> </table>	At Rest	After Exercise	3 Minutes Later				Details of Positive Findings
At Rest	After Exercise	3 Minutes Later						

4. 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

(describe below - if more than one, describe separately)

	Murmur 1.	Murmur 2.			
Location			Indicate:		
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	X	
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	( )	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	O	
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	→	
Systolic	<input type="checkbox"/>	<input type="checkbox"/>			
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>			
Diastolic	<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"/>			
Absent	<input type="checkbox"/>	<input type="checkbox"/>			
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>			
Decreased	<input type="checkbox"/>	<input type="checkbox"/>			

For comments and your impression?

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

(a) Eyes, ears, nose, mouth, pharynx?	Yes	No
(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 (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Any hernias?	<input type="checkbox"/>	<input type="checkbox"/>

6. Are you aware of or do you suspect any other medical, alcoholic or drug history? (If yes, please send a confidential report to the Medical Director)

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

7. Urinalysis: Albumin \_\_\_\_\_ Sugar \_\_\_\_\_ Specific Gravity \_\_\_\_\_  
 In Addition To Performing Above Urinalysis, Please Send Specimen To Lab On ALL Exams.

8. If required, was Blood Sample sent to Lab?  Yes  No  
 If required, have you completed with this exam: An EKG?  Yes  No    A Stress Test?  Yes  No    An X-Ray?  Yes  No

I certify that I have made this examination with the results recorded on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Examination was made at:  My Office     Applicant's residence     Applicant's place of business

\_\_\_\_\_, M.D.  
 Signature of Medical Examiner  
 (Print, type or rubber stamp name of examiner and office address below)  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State & Zip \_\_\_\_\_

1. Name of agent requesting exam \_\_\_\_\_  
 2. Name of person examined \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State & Zip \_\_\_\_\_

**(EXAMINATION NOT TO BE GIVEN TO AGENT)**