

Print full name of Proposed Insured _____ Date of Birth (Month/Day/Year) _____

1. Name & address of your doctor _____
Date last seen _____ Reason & Results _____

2. a. Do you use tobacco or nicotine products? Never Current Past - date last used _____

b. If current or past use, type/amount per day? Cigarettes _____ Pipe/Cigar Chew Patch/gum

3. a. Do you drink alcohol? Never Current Past - date last used/reason quit _____

b. If current or past use, type/amount per week? Beer/Wine _____ Other _____

4. a. List weight change in last year _____ Gain Loss b. Reason _____

5. a. Has any parent or sibling died before age 60? Yes No If yes, ages at death _____

b. Relationship(s) _____ Cause(s) of death _____

6. Within the past 10 years have you had, been treated for, or diagnosed having:

	No	Yes
a. High blood pressure, chest pain, heart attack, or any other disease or disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>

b. Asthma, bronchitis, emphysema, or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
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c. Seizures, stroke, headaches; or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
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d. Ulcer, colitis, cirrhosis, irritable bowel syndrome, hepatitis, or any other disease or disorder of the liver, gallbladder, pancreas, or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
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e. Protein, sugar, or blood in the urine; or any other disease or disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>
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f. Diabetes, thyroid disorder, or any other glandular disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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g. Cancer, tumor, cyst, or other growth (benign or malignant)?	<input type="checkbox"/>	<input type="checkbox"/>
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h. Back or neck pain, spinal strain or sprain, sciatica, arthritis, carpal tunnel syndrome, or any disc, bone, joint or muscle disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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i. Chronic Fatigue Syndrome, Epstein Barr, Lyme's disease or any chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
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j. Depression, stress, anxiety, or any other psychological or emotional disorder or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
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k. Disease or disorder of the genitals or reproductive system, including the prostate, uterus, ovaries or breasts; or any sexually transmitted disease or pregnancy complications?	<input type="checkbox"/>	<input type="checkbox"/>
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l. Disease or disorder of the skin, eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
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7. During the past 10 years have you:

a. Had any illness, injury or health condition not already indicated above; had or been recommended to have any treatment, hospitalization, surgery, medical test or medication?	<input type="checkbox"/>	<input type="checkbox"/>
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b. Seen a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
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c. Been advised to limit or discontinue the use of alcohol or drugs; sought or received treatment, counseling or participated in a group for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
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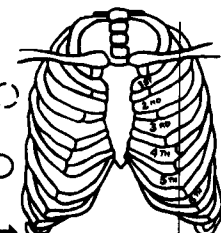
Details of "yes" answers. List question number. Give dates, duration, treatment and doctors' names and addresses:

8. Have you ever had any test which indicated you have been infected with the HIV (AIDS) virus?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Details of "yes" answers:
9. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Date _____	Signed at (City, State) _____	Witness/Title _____	Signature of Proposed Insured X
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MEDICAL EXAMINER'S REPORT

<p>11 a. Height (In Shoes) feet _____ in. _____ ; or cm _____</p> <p>b. Weight (Clothed) pounds _____ ; or kg _____</p> <p>c. Did you weigh? <input type="checkbox"/> No <input type="checkbox"/> Yes Did you measure? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>d. Is appearance unhealthy or older than stated age? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>e. Chest (Full Inspiration) in./cm. _____</p> <p>Chest (Forced Expiration) in./cm. _____</p> <p>Abdomen, at Umbilicus in./cm. _____</p>																											
<p>12. Blood Pressure in sitting position prior to exercise:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:35%;">First Reading</td> <td style="width:50%;">Two additional readings if first greater than 135/85</td> </tr> <tr> <td>Systolic</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Diastolic</td> <td>_____</td> <td>_____</td> </tr> </table>		First Reading	Two additional readings if first greater than 135/85	Systolic	_____	_____	Diastolic	_____	_____	<p>13. Pulse:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">At Rest</td> <td style="width:30%;">After Exercise</td> <td style="width:40%;">3 Minutes Later</td> </tr> <tr> <td>Rate</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Irregularities per min.</td> <td>_____</td> <td>_____</td> </tr> </table>	At Rest	After Exercise	3 Minutes Later	Rate	_____	_____	Irregularities per min.	_____	_____									
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<p>14. Heart: is there any:</p> <p>Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes Dyspnea <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Murmur(s) <input type="checkbox"/> No <input type="checkbox"/> Yes Edema <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>(describe below)</p> <p>Location <input style="width:100px;" type="text"/></p> <p><input type="checkbox"/> Constant Indicate:</p> <p><input type="checkbox"/> Inconstant</p> <p><input type="checkbox"/> Transmitted Apex by X</p> <p><input type="checkbox"/> Localized</p> <p><input type="checkbox"/> Systolic Murmur area by ○</p> <p><input type="checkbox"/> Presystolic Point of greatest intensity by ○</p> <p><input type="checkbox"/> Diastolic</p> <p><input type="checkbox"/> Soft (Gr. 1-2)</p> <p><input type="checkbox"/> Mod. (Gr. 3-4)</p> <p><input type="checkbox"/> Loud (Gr. 5-6) Transmission by →</p>  <p>After exercise:</p> <p><input type="checkbox"/> Increased <input type="checkbox"/> Absent <input type="checkbox"/> Unchanged <input type="checkbox"/> Decreased</p> <p>Your comments and impression?</p>	<p>15. Is there any abnormality of the following (circle applicable items and give details) on examination:</p> <table style="width:100%;"> <tr> <td style="width:80%;">(a) Eyes, ears, nose, mouth, pharynx?</td> <td style="width:10%; text-align:center;"><input type="checkbox"/></td> <td style="width:10%; text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(If vision or hearing markedly impaired, indicate degree and correction.)</td> <td></td> <td></td> </tr> <tr> <td>(b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(c) Nervous system (include reflexes, gait, paralysis)?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(d) Respiratory system?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(e) Abdomen (include scars)?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(f) Genitourinary system (include prostate)?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(g) Endocrine system (include thyroid and breasts)?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>(h) Musculoskeletal system (include spine, joints, amputations, deformities)?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>16. (a) Are there any hernias? <input type="checkbox"/> <input type="checkbox"/></p> <p>(b) Any hemorrhoids? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Are you aware of additional medical history? <input type="checkbox"/> <input type="checkbox"/></p> <p align="center">(A confidential report may be sent to the Medical Director)</p>	(a) Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>	(If vision or hearing markedly impaired, indicate degree and correction.)			(b) Skin (incl. scars); lymph nodes; varicose veins; 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 (include prostate)?	<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"/>
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Give details to "yes" answers:

Urinalysis: S.G. _____ Occ. Blood _____ Sugar _____ Albumin _____ Time collected: _____ Is specimen being sent to Home Office Reference Laboratory? <input type="checkbox"/> No <input type="checkbox"/> Yes	Send Specimen to laboratory: (1) When instructed by agent (2) If applicant is age 60 or over (3) If history reveals G-U or C-V disease or disorder within 5 years (4) Regardless of age when total amount now applied for exceeds \$250,000.
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Name of agent soliciting application: _____ Reason for examination: <input type="checkbox"/> Life <input type="checkbox"/> Group <input type="checkbox"/> Health <input type="checkbox"/> Employment <input type="checkbox"/> Other _____ Examinations made at: <input type="checkbox"/> Examiner's Office <input type="checkbox"/> Applicant's Home <input type="checkbox"/> Other _____	By (print name) _____, _____ M.D. Signature _____ D.O. Address _____ Para Med.
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Send exam to Agency Office or Home Office only. Examiner is welcome to call or write Medical Director with any information considered confidential.