

1. Name of Proposed Insured _____ 2. Date of Birth _____ 3. Social Security Number _____

4. a. Name, address and telephone number of personal physician (if none, physician last consulted) _____

b. Date last consulted, reason and results _____

c. What treatment was given or medication prescribed? _____

5. Within the past 12 months, have you used any substance containing tobacco or nicotine or any nicotine cessation product? (If yes, explain type and frequency of use in Question 9.) Yes No

6. Measured Height ___ ft ___ in. Scale Weight _____ lbs.
 Has your weight changed 10 pounds or more in the past year? _____
 If yes, how much? _____ lbs. Explain in Question 9.

For Questions 7 and 8, please provide diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities in Question 9 below. Also, for each "yes" answer in Question 7, please circle the item to which it applies.

7. To the best of your knowledge and belief, have you ever been treated for or been diagnosed as having:

a. heart attack, angina (or other pain, discomfort, or tightness of the chest), shortness of breath, palpitation, irregular or rapid pulse, heart murmur, rheumatic fever, or any other disease of the heart or blood vessels?	Yes	No
b. high blood pressure, elevated cholesterol, anemia, or any other disease of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
c. dizziness or headaches, fainting spells, convulsions, seizures, epilepsy, stroke, Alzheimer's disease, multiple sclerosis, neurosis, affective disorder, psychosis, or any other brain, nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. asthma, emphysema, tuberculosis, coughing or spitting blood, bronchitis, persistent cough, or any other disease of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. any disorder or disease of the eyes (not fully corrected by glasses), ears, nose or throat, hearing or speech?	<input type="checkbox"/>	<input type="checkbox"/>
f. recurrent indigestion or abdominal pain, colitis, ulcer, hernia, persistent diarrhea, rectal bleeding, or any other disease or disorder of the stomach, intestines, or rectum?	<input type="checkbox"/>	<input type="checkbox"/>
g. nephritis, sexually transmitted disease, or any other disease of the kidneys, bladder, prostate, testes, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
h. sugar, albumin, blood, or pus in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
i. diabetes, jaundice, or any disease of the liver, pancreas, thyroid or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>
j. disorder of any glands or immune system disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k. cancer, or any malignant or benign tumor or cyst (lumps or growth), or any disease of the skin or lymph glands?	<input type="checkbox"/>	<input type="checkbox"/>
l. arthritis, rheumatism, chorea, or gout; or any chronic back, neck, spine, joint, or muscle condition?	<input type="checkbox"/>	<input type="checkbox"/>
m. phlebitis, swelling of legs or ankles, varicose veins, or any deformity, paralysis, or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>
n. use of alcohol, marijuana, hallucinogens, stimulants, sedatives, or narcotics or taken any treatment for alcohol or drug use (kind and amount used)?	<input type="checkbox"/>	<input type="checkbox"/>
o. AIDS (acquired immune deficiency syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>
p. any chronic or persistent disease, infection or disorder, injury or operation not mentioned previously?	<input type="checkbox"/>	<input type="checkbox"/>

Within the past 5 years, have you:

a. consulted, or been examined or treated by any physician, chiropractor, or other medical practitioner or by any hospital, clinic, or other medical facility not previously mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
b. had any X-rays, electrocardiograms, or other medical tests, that were not covered above?	<input type="checkbox"/>	<input type="checkbox"/>
c. been advised to have surgery, hospitalization, treatment, or test, that was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
d. taken any drug or medicine prescribed by a physician or other practitioner?	<input type="checkbox"/>	<input type="checkbox"/>

Question No. & Letter	Date	Details (be specific - give full names, addresses of physicians, hospitals, etc.)

	Age if Living	Cause of Death	Age at Death	No. Living	Ages if Living	No. Deceased	Causes of Death	Ages at Death
Father				Brothers				
Mother				Sisters				

The statements and answers on this medical examination form are complete and true to the best of my knowledge and shall become part of my application for life insurance.

Signed at _____
 (City & State) _____
 Signature of _____
 Medical Examiner _____

On (Date) _____
 Signature of _____
 Proposed Insured _____

11. Chest (full inspiration) ___ In. Abdomen (at umbilicus) ___ In.	12. Blood Pressure: Record two additional blood pressure readings if the initial blood pressure is greater than 145 systolic or 90 diastolic. 1st Reading 2nd Reading 3rd Reading Systolic _____ Diastolic _____	13. Pulse	at rest	After Exercise (15 squats- equiv.)	3 mins. later
		Pulse Rate _____	_____	_____	_____
		Irregularities per min. _____	_____	_____	_____

14. CARDIOVASCULAR EXAM FINDINGS: Please explain any "yes" answers in Remarks section below.

	Yes	No			
a. Increased AP diameter of chest	<input type="checkbox"/>	<input type="checkbox"/>	k. Heart murmur(s)		
b. Abnormal lung sounds	<input type="checkbox"/>	<input type="checkbox"/>	Location _____		If murmur present, does:
c. Gallop sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Constant or <input type="checkbox"/> Inconstant		Exercise <input type="checkbox"/> Increase or <input type="checkbox"/> Decrease
d. Absent radial or pedal pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Transmitted or <input type="checkbox"/> Localized		Standing <input type="checkbox"/> Increase or <input type="checkbox"/> Decrease
e. Cardiac enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Systolic or <input type="checkbox"/> Diastolic		Squatting <input type="checkbox"/> Increase or <input type="checkbox"/> Decrease
f. Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Soft (gr.1-2) <input type="checkbox"/> Moderate (gr.3-4) <input type="checkbox"/> Loud (gr.5-6)		
g. Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	Examiner's Clinical Impression of Murmur _____		
h. Clubbing of fingers	<input type="checkbox"/>	<input type="checkbox"/>	Additional findings _____		
i. Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>			
j. Other abnormal sounds	<input type="checkbox"/>	<input type="checkbox"/>			

15. OTHER (Explain "yes" answers in Remarks section below; circle each applicable item.) On examination, is there any abnormality of the following:	Yes	No	16. a. Have you seen the Proposed Insured professionally before this exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes	No
a. Head and neck, vision and eyes, hearing and ears, nose, mouth, throat or thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	c. Can the Proposed Insured speak and understand English? (If no, explain.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Skin (include scars and tattoos) or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	d. Was any third party present during the examination? (If yes, give name, relationship, and reason for presence.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Nervous system (include reflexes, gait, paralysis, memory)?	<input type="checkbox"/>	<input type="checkbox"/>			
d. Chest (include lungs)?	<input type="checkbox"/>	<input type="checkbox"/>	17. After reviewing the answers and as a result of your examination, do you find any evidence of any past or present disease not specifically mentioned in this application? <input type="checkbox"/> Yes <input type="checkbox"/> No		
e. Abdomen (include liver, spleen and scars)?	<input type="checkbox"/>	<input type="checkbox"/>			
f. Musculoskeletal system (include spine, joints, amputation, and deformities)?	<input type="checkbox"/>	<input type="checkbox"/>			
g. Vascular system (include varicose veins and peripheral arteries)?	<input type="checkbox"/>	<input type="checkbox"/>			

REMARKS (Identify question number with each explanation.)

3. Where was this examination made? Examiner's office Agent's office
 Proposed Insured's Residence Proposed Insured's Place of Business
 Other _____

Examiner's Name and Professional Designation _____

.S.N. or Tax I.D. No. _____ Telephone No. () _____ Exam Fee \$ _____

Name and Address of Examiner's Firm _____

Time and Date of Examination: Time _____ AM _____ PM Date _____

Name of Agent _____
 Requesting Examination _____ Examiner's Signature _____

(please print)

**NOTICE AND CONSENT FOR BLOOD TESTING
WHICH INCLUDES AIDS VIRUS (HIV) ANTIBODY TESTING**

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory. A test will be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The series consists of two ELISA tests followed by a Western Blot test. The test is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies is other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV antibody test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV antibody test result is normal, no routine notification will be sent to you. If the HIV antibody test result is other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

A positive HIV antibody test result does not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. A negative HIV antibody test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not necessarily mean that you have not been infected with the virus.

A positive HIV antibody test result or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Additional information concerning the meaning of the test and the interpretation of the results of the test may be obtained from a private physician, the County Department of Health, the State Department of Health Services, local Medical Societies, or Alternative Test Sites.

I have read and I understand this Notice and Consent for Blood Testing Which Includes AIDS Virus (HIV) Antibody Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the 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. This authorization is valid for six months.

NAME OF PROPOSED INSURED (PLEASE PRINT)		BIRTHDATE
SIGNATURE OF PROPOSED INSURED	DATE SIGNED	STATE OF RESIDENCE CALIFORNIA

12-2950 (California - Northern)

Copy 1 - Insurer Copy 2 - Proposed Insured