

Provident Mutual Life Insurance Company
 Provident Mutual Life and Annuity Company of America
A Stock Life Insurance Company

MEDICAL EXAMINATION

PC 0111

1. Name of Proposed Insured _____	2. Date of Birth _____	3. Social Security Number _____
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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. Yes No
Has your weight changed 10 pounds or more in the past year? _____ Yes No
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:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> |

8. Within the past 5 years, have you:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 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								
Mother				Brothers				
				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
a. Head and neck, vision and eyes, hearing and ears, nose, mouth, throat or thyroid?	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (include scars and tattoos) or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis, memory)? ..	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest (include lungs)?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

16. a. Have you seen the Proposed Insured professionally before this exam?	Yes	No
b. Is the Proposed Insured's appearance unhealthy, unusual, or older than stated age?	<input type="checkbox"/>	<input type="checkbox"/>
c. Can the Proposed Insured speak and understand English? (If no, explain.)	<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"/>	<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"/>	<input type="checkbox"/>

REMARKS (Identify question number with each explanation.)

18. 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.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 _____ (please print) Examiner's Signature _____

0102

Provident Mutual Life Insurance Company of Philadelphia
P.O. Box 7378, Philadelphia, PA 19101

Provident Mutual Life and Annuity Company of America
A STOCK LIFE INSURANCE COMPANY
P.O. Box 7378, Philadelphia, PA 19101

Authorization to Physicians, Practitioners and Hospitals or other Institutions

Name of Proposed Insured (Print)	Agency No. 051
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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. The Company, its reinsurers, insurance support organizations, and their authorized representatives, may obtain medical and other information in order to evaluate my (our) application for life or health insurance.
2. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc. ("MIB"), my employer and consumer reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to the Company upon presenting this authorization or a photocopy. If family insurance is applied for, this authorization shall pertain to me or the members of my family. No information obtained from MIB pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this policy, except upon written consent to be medically tested for HIV or AIDS and the results of such testing prove positive.
3. This authorization includes information about drugs, alcoholism or mental illness.
4. The Company or its reinsurers may make a brief report regarding me or members of my family to other companies to whom I have applied or may apply.
5. This authorization will be valid from the date signed for a period of 30 months (26 months in MN).
6. I authorize the Company to obtain an investigative consumer report on me. Upon written request, I may receive a copy of it.
7. I elect to be interviewed if an investigative consumer report is prepared in connection with this application. Please check if interview is desired.
8. I have read this authorization and have received a copy. Copies of the "Notice of Insurance Information Practices" and "Investigative Consumer Report Notification" and the "MIB Disclosure Notice" are printed on the reverse side of this authorization.

Date	Signature of Proposed Insured
	Signature of Parent if Proposed Insured is a Child

The Proposed Insured should retain the copy of this authorization; the original will be retained by the Company. Send to me in the office with every Application For New Insurance, Policy Change, Reinstatement or Surrender which requires Evidence Of Insurability