

<p>1. PROPOSED INSURED Print Full Name _____</p>	<p>2. DATE OF BIRTH Month _____ Day _____ Year _____</p>																					
<p>3. A. Have any of your near relatives had diabetes? _____ A. <input type="checkbox"/> Yes <input type="checkbox"/> No B. Has your weight changed in the past year? _____ B. <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", give pounds gained or lost and reason. C. Have you ever had any physical disability or impairment? C. <input type="checkbox"/> Yes <input type="checkbox"/> No D. Is your health impaired at present? _____ D. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>IMPORTANT—Report Nature of Disorder, Diagnosis and dates of each YES ANSWER to questions 4 thru 10. (Include frequency, treatment, medication, surgery and results). Also report Names and addresses of each physician or hospital used unless shown below in 11.</p>																					
<p>4. A. Have you ever been treated or counseled for the excessive use of barbiturates, amphetamines, marijuana, other hallucinatory drugs, heroin, opiates or other narcotics? _____ A. <input type="checkbox"/> Yes <input type="checkbox"/> No B. Have you ever been treated or counseled for excessive use of alcohol? _____ B. <input type="checkbox"/> Yes <input type="checkbox"/> No C. Have you smoked a cigarette within the past 12 months? _____ C. <input type="checkbox"/> Yes <input type="checkbox"/> No D. Do you use tobacco in any form? _____ D. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>5. DURING THE PAST FIVE YEARS HAVE YOU: A. Consulted, been examined or been treated by any physician or practitioner? If "yes", give specific reason _____ A. <input type="checkbox"/> Yes <input type="checkbox"/> No B. Had an X-ray, electrocardiogram or any laboratory test or study? _____ B. <input type="checkbox"/> Yes <input type="checkbox"/> No C. Had observation of treatment at a clinic, hospital, or sanitarium? _____ C. <input type="checkbox"/> Yes <input type="checkbox"/> No D. Had or been advised to have a surgical operation? _____ D. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>6. Are you now under treatment or taking any medication? If "yes", list reason, type and amount _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>7. Have you ever had, been told you had or diagnosed as having symptoms, disorder, disease, or persistent discomfort of: A. Respiratory system (lungs, bronchi, trachea, etc.) such as TB, asthma, emphysema, bronchitis? _____ A. <input type="checkbox"/> Yes <input type="checkbox"/> No B. Circulatory system (heart, blood, arteries, veins, etc.) such as high blood pressure, heart attack, murmur, chest pains? _____ B. <input type="checkbox"/> Yes <input type="checkbox"/> No C. Digestive system (esophagus, stomach, intestine, liver, gall bladder, etc.) such as ulcer, cirrhosis, hemorrhoids, bleeding? _____ C. <input type="checkbox"/> Yes <input type="checkbox"/> No D. Nervous system (brain, nerves, etc.) such as paralysis, fainting, epilepsy, convulsions, mental or nervous disorders? _____ D. <input type="checkbox"/> Yes <input type="checkbox"/> No E. Muscular and skeletal systems (muscles, bones, joints, spine, etc.) such as neck or back problems, fracture, arthritis, rheumatic fever? _____ E. <input type="checkbox"/> Yes <input type="checkbox"/> No F. Genito-urinary system (kidney, bladder, reproductive organs, etc.) such as infection, bleeding, male or female disorders? _____ F. <input type="checkbox"/> Yes <input type="checkbox"/> No G. Glandular system (thyroid, pancreas, adrenal, lymph glands, etc.) such as diabetes, or abnormal growth or function? _____ G. <input type="checkbox"/> Yes <input type="checkbox"/> No H. Acquired Immune Deficiency Syndrome (AIDS), "AIDS" related complex (ARC), or "AIDS" related condition. _____ H. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>8. Do you have or have you had impaired sight or hearing, cancer or growth, venereal disease, hernia, or skin disease? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>9. A. Have you ever had ANY DISORDER of the breasts or of menstruation? _____ A. <input type="checkbox"/> Yes <input type="checkbox"/> No B. Are you pregnant? _____ B. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						
<p>10. FAMILY RECORD: Show age and present health, or if deceased, show age at death and cause of death.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Age</th> <th>Present Health</th> <th>Cause of Death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Brothers</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Sisters</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Age	Present Health	Cause of Death	Father				Mother				Brothers				Sisters				
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<p>11. NAME AND ADDRESS OF PERSONAL PHYSICIAN</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>A. Date last seen? _____</p> <p>B. For what reason? _____</p> <p>_____</p>																						

I represent that the statements and answers shown above are complete and true to the best of my knowledge and belief.

Signed at _____ (City) _____ (State) on _____ (Date), 20____

Witness _____ SIGNATURE OF MEDICAL EXAMINER _____ SIGNATURE OF PROPOSED INSURED _____

Part III — MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

1. NAME OF PROPOSED INSURED _____

2. BLOOD PRESSURE—If 1st reading is over 140/90 obtain 2 additional readings at 5 minute intervals.

	1.	2.	3.
Systolic	mm	mm	mm
Diastolic (Phase v)	mm	mm	mm

3. A. Height Ft. In. B. Weight Pounds 4. Temperature _____

5. A. Chest Expanded In. B. Chest Contracted In. C. Abdomen In. _____

6. _____ Before Exercise Immediately After Three Minutes After PULSE RATE _____ IRREGULARITIES _____

7. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

A. BRAIN, NERVOUS SYSTEM? (Test reflexes and Coordination.) _____ A. Yes No

B. EARS, NOSE, EYES, THROAT, TEETH OR GUMS? _____ B. Yes No

C. THYROID OR LYMPH GLANDS? _____ C. Yes No

D. HEART, BLOOD VESSELS? _____ D. Yes No
(If you find any abnormality of Heart size, rhythm or sounds, please complete Question No. 13.)

E. LUNGS? _____ E. Yes No

F. STOMACH OR ABDOMINAL ORGANS? _____ F. Yes No

G. GENITO-URINARY SYSTEM? _____ G. Yes No

H. SKIN OR EXTREMITIES? _____ H. Yes No

8. A. Does appearance indicate poor health or older than stated age? _____ A. Yes No

B. Do you know or suspect that the proposed insured:

1. Is a habitual smoker? _____ 1. Yes No

2. Is a habitual user of drugs? _____ 2. Yes No

3. Is a habitual user of alcoholic beverages to excess? _____ 3. Yes No

4. Participates in a physical fitness program? _____ 4. Yes No

C. Do you know any facts affecting health not brought out above? _____ C. Yes No

9. URINALYSIS:

SPECIFIC GRAVITY	BLOOD	ALBUMIN	SUGAR
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INSTRUCTIONS TO EXAMINER
In addition to the above urinalysis, mail a specimen of urine to the home office reference lab. If unable to mail a specimen, please indicate reason for delay:

10. Have you seen the Proposed Insured professionally before? _____ Yes No

If yes, when and why? _____

11. Are you in any way related to the Proposed Insured or to the Agent? _____ Yes No

12. Name of Agent requesting examination. _____

EXAMINATION WAS MADE IN PRIVATE AT:

My Office

Residence of Proposed Insured

Place of Business of Proposed Insured

AT _____ PM on _____, 20____

 AM

13. TO BE COMPLETED IF QUESTION 7D IS ANSWERED "YES"
A. Is there a history of rheumatic fever, cholera, scarlet fever diphtheria, recurrent tonsillitis syphilis? _____

B. Is there a Murmur? Yes No

Timing	Intensity	Quality
<input type="checkbox"/> Systolic	<input type="checkbox"/> Faint (Gr. 1-2)	<input type="checkbox"/> Soft
<input type="checkbox"/> Presystolic	<input type="checkbox"/> Mod. (Gr. 3-4)	<input type="checkbox"/> Blowing
<input type="checkbox"/> Diastolic	<input type="checkbox"/> Loud (Gr. 5-6)	<input type="checkbox"/> Rough

C. Is the murmur constant or inconstant? Constant Inconstant

D. Transmitted? Yes No

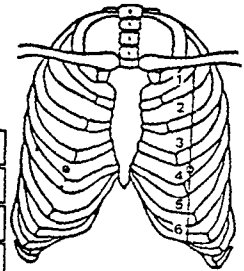
E. On exercise, does the murmur Intensity? Decrease? Disappear?

F. Show location of murmur. Apex by _____

Area of murmur by outline _____

Point of greatest intensity _____

Transmission _____



G. Is hypertrophy present? _____

H. Apex beat is _____ cm. to left midsternal line in the _____ interspace.

I. What is your impression of the murmur? _____

DETAILS — PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS AND OPINIONS.

PARA-MEDICAL EXAMINATION SERVICE ON MONTHLY BILLING X HERE _____ OTHERWISE

PLEASE ATTACH STATEMENT OF FEE OR RECORD CHARGES HERE \$ _____

NAME OF EXAMINER _____ Please Print or Type

SIGNATURE OF EXAMINER _____

Address _____

City _____ State _____ Zip _____

EXAMINER'S FEE VOUCHER

Do Not Detach

We pay the usual reasonable and customary fee.

Name of Person examined _____ Date of Examination _____ My Fee \$ _____

Name of Agent requesting examination _____ Agency _____

Name of Medical Examiner _____ (Please print or use rubber stamp)

Address: Street and No. _____

City, State and Zip Code _____

USE REVERSE SIDE FOR CONFIDENTIAL REMARKS OR INFORMATION