

APPLICATION PART II - MEDICAL EXAMINATION

Administrative Office:
ING Service Center
2000 21st Ave. NW
Minot, ND 58703

- ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO

Name of Proposed Insured Date of Birth SSN

Name of personal physician or clinic Telephone Number

Address of personal physician or clinic

Date last consulted Reason for, and results of consultation

- 1. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having:
a. Dizziness, fainting, seizures, convulsions, optic neuritis, headache, paralysis, stroke, TIA, mental or nervous disorder, including anxiety or depression?
b. Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, emphysema, tuberculosis, or chronic respiratory disorder?
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder?
e. Sugar, albumin, blood or pus in urine, sexually transmitted disease, nephritis, stone, or other disorder of kidney, bladder, breasts, prostate, or reproductive organs?
f. Diabetes, thyroid, or other endocrine disorder?
g. Disorder of the skin or lymph glands, arthritis, or disorder of the muscles, joints or bones?
h. Anemia or other disorder of the blood?
i. Positive HIV (Human Immunodeficiency Virus) test, AIDS (Acquired Immunodeficiency Syndrome), or other disease or disorder of the immune system in connection with an application for insurance?
2. Have you:
a. Experienced any symptom(s) for which you have not yet consulted a health care provider?
b. Had any operation(s) in the past 10 years?
c. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests not yet performed?
d. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years?
e. Sought or been advised to seek advice or treatment for the use of alcohol?
f. In the past 10 years been confined for observation, care, or treatment in a hospital or other health care facility?
g. In the past 5 years consulted any health care provider(s), not already identified, for any reason including routine physical examination?
h. Ever had a tumor, pre-cancerous lesion or cancer?
3. Are you:
a. Presently taking any medication(s), including non-prescription/over the counter medication or supplements?
b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider?

MEDICAL EXAMINER'S REPORT Provide further clarification in space provided below.

- 1a. How long have you known the Proposed Insured? _____
 b. Are you related to him/her or to the agent? ... Yes No
 2a. Exact weight _____ b. Exact height _____
 c. Weight increase/decrease in last year _____
 d. Girth (males only)
 Chest at forced expiration _____ Abdomen _____

3a. Blood Pressure: (Use right arm while seated. Two readings are recorded, none disregarded.) If systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 minutes of rest.

| | 1st | 2nd | 3rd | 4th |
|-----------|-----|-----|-----|-----|
| Systolic | | | | |
| Diastolic | | | | |

- b. Rate of Pulse _____
 4a. Have the blood and urine specimens been sent?.. Yes No
 b. Lab ticket number _____
 c. Name of Lab _____

5. Was the EKG completed? (if required)..... Yes No

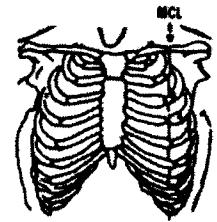
6. For females only.
 a. Was the Proposed Insured menstruating at the time the urine specimen was voided? Yes No
 b. Is the Proposed Insured pregnant? Yes No
 7. Does the Proposed Insured currently use or has he or she ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches? Yes No
 If "Yes", type and daily amount _____
 Date last used _____

- 8a. Peripheral pulses: Normal Decreased
 b. Is there any irregularity or abnormality of the cardiac rhythm?..... Yes No
 Nature of irregularity _____
 Number of irregularities per minute _____
 Number of irregularities after exercise _____

- c. Is there any abnormality of the quality or intensity of the heart sounds?..... Yes No
 d. Are there any heart murmurs?..... Yes No
 If "Yes", diagnosis: Functional Organic
 Type _____

- Please indicate:
- | Timing | Intensity | Quality |
|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Systolic | <input type="checkbox"/> Faint | <input type="checkbox"/> Soft |
| <input type="checkbox"/> Presystolic | <input type="checkbox"/> Moderate | <input type="checkbox"/> Blowing |
| <input type="checkbox"/> Diastolic | <input type="checkbox"/> Loud | <input type="checkbox"/> Rough |

Indicate on diagram point of maximum intensity or murmur with O and direction of transmission with →



- e. Is the heart enlarged?..... Yes No
 9. Have you found any evidence of past or present disease of:
 a. Head or neck?..... Yes No
 b. Eyes, ears, nose or throat? Yes No
 c. Lymph nodes? Yes No
 d. Brain or nervous system? Yes No
 e. Lungs or chest?..... Yes No
 f. Abdomen? Yes No
 g. Genito-urinary system? Yes No
 h. Extremities or Peripheral vessels?..... Yes No
 i. Skin?..... Yes No
 j. Any other part of the body?..... Yes No
 Explain any "Yes" answers in #12.
 10a. Is there evidence of dementia?..... Yes No
 b. Is there any evidence the Proposed Insured is unable to perform independent activities of daily living? (IADL) Yes No
 11. If your examination revealed any condition requiring further investigation or immediate treatment, have you advised the Proposed Insured? Yes No

12. Remarks and Explanations _____

To the Medical Examiner: Any erasures or alterations in this report should be initialed by you.

Examination was made at: Proposed Insured's Residence Proposed Insured's Business Examiner's Office Other _____

Examiner's Name (please print) _____

Examiner's Signature _____ Date Signed _____

Examiner's Address _____

Board Certified Board Eligible Phone Number _____ SSN/TIN _____