

NOTE!  
See Instructions  
below



**Royal Neighbors**  
OF AMERICA  
Fraternal Life Insurance Since 1895

230 Sixteenth St.  
Rock Island, IL 61201  
800-627-4762

**STATEMENT TO MEDICAL EXAMINER**

THE FOLLOWING ANSWERS AND STATEMENTS ARE A CONTINUATION OF AND FORM A PART OF MY APPLICATION FOR LIFE INSURANCE TO ROYAL NEIGHBORS OF AMERICA

Name of applicant _____		Date of birth _____		17 a. When did you last consult a physician or practitioner? _____	
15. Have you lost or gained weight during the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, give details: _____				b. Give reason for consultation and results _____	
				c. Give details of any treatment prescribed _____	
				d. Name, address and phone number of physician or practitioner _____	
				e. List all currently prescribed medications _____	
16a. Family Record		Living		Dead	
	Age	State of Health	Age at Death	Cause of Death	
Father					
Mother					
Brothers & Sisters					
Number living _____					
Number dead _____					
16b. Have any of your parents, brothers or sisters ever had heart disease, diabetes or mental illness? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, give details: _____				18. In the past 5 years, have you used:	
				YES	NO
				a. Barbiturates, sedatives or tranquilizers other than on a doctor's prescription? <input type="checkbox"/>	<input type="checkbox"/>
				b. LSD, marijuana, cocaine or any amphetamine? <input type="checkbox"/>	<input type="checkbox"/>
				c. Heroin, morphine or other narcotic drug? <input type="checkbox"/>	<input type="checkbox"/>

19a. How many children have you had? _____	b. Number living _____	c. Date of last childbirth _____	d. Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO	e. Length of current pregnancy _____ mo.
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20. Have you ever had or been told that you had: YES NO

a. An operation, amputation, deformity, lameness or any impairment of sight or hearing?

b. High blood pressure, stroke or any disease or disorder of the heart, blood or circulatory system?

c. Chest pains, heart murmur, rheumatic fever, nephritis, goiter, fainting spells or dizziness?

d. Cancer, diabetes, emphysema, asthma or any disease or disorder of the lungs or respiratory system?

e. Recurrent indigestion, colitis, intestinal bleeding, ulcer, hernia or any disorder of the liver, gall bladder or intestinal tract?

f. Paralysis, epilepsy, nervous breakdown or any disease or disorder of the brain or nervous system?

g. Kidney stones or any disease or disorder of the genitourinary system (kidney, bladder, prostate, etc.)?

h. Arthritis, rheumatism, gout or any disease or disorder of the muscles, skin, bones, joints or glands?

i. Any tumor or disease of the breast, uterus or tubes or had a Caesarean section or any abnormal pregnancy or labor?

Give full details below for any YES answers to question 20:

Ques. No.	Specify condition	Date	No. of attacks	Duration	Results	Hospital and/or Physician	Address
20							
20							
20							
20							

21. Other than noted above, within the past 5 years, have you:	YES	NO	Give full details including dates and results for any YES answers to Questions 21a, b or c.
	a. Been treated by a physician, or been in a hospital, clinic, sanitarium or institution for observation, diagnosis, operation or treatment? <input type="checkbox"/>	<input type="checkbox"/>	
	b. Had X-ray, electrocardiogram, blood studies or other diagnostic tests? <input type="checkbox"/>	<input type="checkbox"/>	
c. Been advised to have any operation or test not yet performed? <input type="checkbox"/>	<input type="checkbox"/>		

I hereby state that I am the person named as the applicant. I have read all of the foregoing answers and statements, adopt them as my own, whether written by me or not, and hereby declare that they are complete and true to the best of my knowledge and belief. I hereby agree that all of said answers and statements shall be taken as, and be a part of, my said application and be subject to the agreements therein contained.

Dated at (City and State) \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Witnessed by \_\_\_\_\_ Signature of Applicant \_\_\_\_\_  
(Medical Examiner)

Form 1705; Rev. 7-91

**INSTRUCTIONS FOR MEDICAL EXAMINER**

- The applicant should be asked the questions on the "Statement to Medical Examiner" and the answers should be written by you.
- After completion, the "Statement to Medical Examiner" should be signed by the applicant and inspected and signed by you as witness to the applicant's signature.
- The "Medical Examiner's Report" must be completed and signed by you. Also complete the "Medical Examiner's Voucher" as it constitutes your bill for this service.
- Mail the completed form including the voucher.

## MEDICAL EXAMINER'S REPORT

*NOTE: The answers to all questions on this page must be personally written by the Medical Examiner.*

### 1. MEASUREMENTS

a) HEIGHT (in shoes)	b) WEIGHT (in clothes)	c) Did you weigh? <input type="checkbox"/> YES <input type="checkbox"/> NO	f) Males Only						
		d) Did you measure? <input type="checkbox"/> YES <input type="checkbox"/> NO	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Chest (full inspiration)</td> <td style="width: 33%;">Chest (forced expiration)</td> <td style="width: 33%;">Abdomen, at umbilicus (relaxed)</td> </tr> <tr> <td style="text-align: center;">in.</td> <td style="text-align: center;">in.</td> <td style="text-align: center;">in.</td> </tr> </table>	Chest (full inspiration)	Chest (forced expiration)	Abdomen, at umbilicus (relaxed)	in.	in.	in.
Chest (full inspiration)	Chest (forced expiration)	Abdomen, at umbilicus (relaxed)							
in.	in.	in.							
ft.	in.	lbs.							

e) Weight change in past year? \_\_\_\_ lbs.  LOSS  GAIN Cause? \_\_\_\_\_

### 2. CARDIOVASCULAR EXAMINATION

a) BLOOD PRESSURE-If systolic reading is over 140 or diastolic is over 90, take and record three readings.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic - 5th Phase (disappearance of sound)			

b) Examine heart in upright and recumbent positions before and after exercise (15 bends). Do not exercise if contraindicated.

PULSE (Seated)	At Rest	After Exercise	After 5 min.
Rates per minute			
Irregularities per min.			

c) Is heart enlarged?  YES  NO If YES, describe below and complete 2(e). \_\_\_\_\_

d) Is murmur present?  YES  NO If YES, complete 2(e). \_\_\_\_\_

e) To be completed if any abnormality of heart size or murmur.

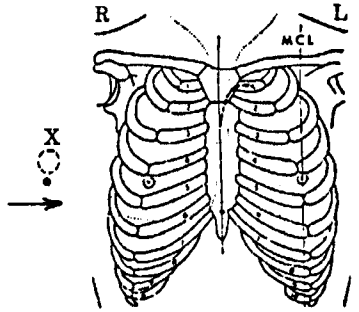
1. Murmur is:
- |                                      |                                      |                                   |  |
|--------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Constant    | <input type="checkbox"/> Systolic    | <input type="checkbox"/> Aortic   | <input type="checkbox"/> Soft (Gr 1-2) |
| <input type="checkbox"/> Inconstant  | <input type="checkbox"/> Presystolic | <input type="checkbox"/> Pulmonic | <input type="checkbox"/> Mod. (Gr 3-4) |
| <input type="checkbox"/> Transmitted | <input type="checkbox"/> Diastolic   | <input type="checkbox"/> Apical   | <input type="checkbox"/> Loud (Gr 5-6) |
| <input type="checkbox"/> Localized   |                                      |                                   |  |

2. After exercise:
- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Unchanged | <input type="checkbox"/> Increased |
| <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent    |

3. Is there a thrill?  YES  NO

4. Locate:  
apex by \_\_\_\_\_  
area of murmur by outline \_\_\_\_\_  
point of greatest intensity by \_\_\_\_\_  
transmission by \_\_\_\_\_

5. Your impression?  
\_\_\_\_\_  
\_\_\_\_\_



### 3. EXAMINATION

Is there on examination any abnormality of the following:  
(Circle applicable items and give details.)

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| a) Eyes, ears, nose, mouth, pharynx? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| (If vision or hearing markedly impaired, indicate degree and correction.)              |                          |                          |
| b) After examining eye grounds, do you find evidence of disease? . .                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Type . . . . . Circle appropriate grade - 1, 2, 3, 4                                   |                          |                          |
| c) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Nervous system (includes reflexes, gait, paralysis)? . . . . .                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Respiratory system? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Abdomen (include scars)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Genitourinary system (include prostate)? . . . . .                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Endocrine system (include thyroid and breasts)? . . . . .                           | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Musculoskeletal system (include spine, joints, amputations, deformities)? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Are there any hernias? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Are you aware of additional medical history? . . . . .                              | <input type="checkbox"/> | <input type="checkbox"/> |
- (A confidential report may be sent to the Medical Director.)

Details of "YES" answers (Identify Item)

### 4. URINALYSIS

Specific Gravity	Reaction	Albumin	Sugar	Test Used

Are you positive the urine specimen was voided by the applicant?  YES  NO  
If a) Sugar or Albumin found OR b) history of GU disorder, Glycosuria or Albuminuria, identify as Royal Neighbors and send specimen to:  
Osborn Laboratories, P.O. Box 2920, Shawnee Mission, KS 66201

5. How long have you known the applicant? \_\_\_\_\_

I certify that I have carefully examined the applicant and that, in my opinion, the foregoing statements and answers on this page are true.

This examination was made on: Date \_\_\_\_\_  
From what Medical School did you graduate? \_\_\_\_\_

Examiner's Signature \_\_\_\_\_

Examiner's Address \_\_\_\_\_

City, State & Zip Code \_\_\_\_\_

Year of graduation \_\_\_\_\_

(DO NOT DETACH)

### MEDICAL EXAMINER'S VOUCHER

(DO NOT DETACH)

Amount of Fee-\$50.00

Please TYPE or PRINT INFORMATION REQUIRED BELOW

Name of Applicant examined		Date examined	For Office Use Only
Make check payable to:			Order No. _____
Mail check to:			Amount \$ _____
			Approved by _____
			Date _____