



4343 N. Scottsdale Rd., Suite 300  
Scottsdale, AZ 85251 / 800-531-5067

**STATEMENT TO THE MEDICAL EXAMINER  
IN CONTINUATION OF AND FORMING A PART OF MY  
APPLICATION FOR INSURANCE**

**USE BLACK INK ONLY**

**PART TWO** This Examination must be made in private and answers inserted in Examiner's own HANDWRITING.

Name of Proposed Insured:	Birthdate			Sex	Name of Soliciting Salesman:	
	Mo.	Day	Yr.			
Has your application for Life or Health Insurance ever been declined, postponed, or limited to a policy different from the one applied for, or has any Company ever declined your application to reinstate any policy? (State Company and details)				YES <input type="checkbox"/> NO <input type="checkbox"/>	Examination made in private at ___ A.M. ___ P.M.	<input type="checkbox"/> Examiner's Office <input type="checkbox"/> Proposed Insured's Home <input type="checkbox"/> Proposed Insured's Office

MEDICAL HISTORY (to be recorded by medical examiner)	YES	NO	
So far as you know and believe:			<b>Please provide details</b> <b>Name, Address and Phone Numbers of all Doctors:</b>
1. Have you ever had any physical disability or impairment.....	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is your health impaired at present.....	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the proposed insured within the last ten years: Had or been treated for any disorder of:			
(a) The heart or circulatory system, chest pain, high blood pressure, stroke or headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Veins, arteries, blood, or lymph nodes.....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Lungs, asthma, emphysema, tuberculosis, or respiratory disease...	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Brain or nervous system, paralysis, convulsions, mental or nervous condition.....	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Stomach, liver, intestines, rectum, or gall bladder.....	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Pancreas, thyroid, glandular disorder, diabetes, or high or low blood sugar.....	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Back, spine, bones, joints, muscles, skin, arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	
(h) Kidneys, bladder, prostate, breast, urinary or reproductive organs, syphilis, gonorrhea, or other sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>	
(i) Eyes, ears, nose, throat, or loss of limb.....	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ever had or been treated for any cancer or tumor.....	<input type="checkbox"/>	<input type="checkbox"/>	
5. Ever been told you have or been treated by a member of the medical profession for Acquired Immune Deficiency Syndrome, AIDS Related Complex, or any disorder of the immune system.....	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ever been treated for alcohol or drug abuse.....	<input type="checkbox"/>	<input type="checkbox"/>	
7. In the last five years experienced unintentional weight loss of more than ten pounds, fever or swollen glands, chronic fatigue or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	
8. Been confined to any hospital, clinic, or sanatorium in the last five years..	<input type="checkbox"/>	<input type="checkbox"/>	
9. In the last five years seen any doctor, or had any illness, medical treatment, exam or surgery or taken any medication not mentioned above.....	<input type="checkbox"/>	<input type="checkbox"/>	
10. Been rejected or discharged from the military for medical reasons.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Used any form of tobacco in the last two years.....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Had an immediate family member who has had a heart attack, angina, stroke, cancer, diabetes, or chronic kidney disease..... If Yes, indicate relationship, impairment, and age at diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. Are you presently taking any medication.....	<input type="checkbox"/>	<input type="checkbox"/>	

Name and Address of the Physician having the most complete Medical Records:	The Date and Reason for your Last Visit:
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So far as I know and believe, the answers given above are true and complete. I agree that they, with the statements in my application, will be the basis for and a part of any insurance issued.

\_\_\_\_\_  
Medical Examiner

\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Date

# MEDICAL EXAMINER'S REPORT

## PART THREE

THIS REPORT IS

CONFIDENTIAL BETWEEN

TO BE COMPLETED IN PRIVATE

COMPANY AND EXAMINER

Examination of heart and lungs must be with stethoscope against bared skin

BY EXAMINER ONLY.

EXAMINATION OF:

PLEASE GIVE FULL DETAIL OF ADVERSE

(Print full name)

FINDINGS IN "DETAILS" SPACE BELOW

14. A. HEIGHT (in shoes) \_\_\_ft. \_\_\_in. Exact Scale  
 B. WEIGHT (in clothes) \_\_\_pounds  
 C. GIRTH (males only) Chest at forced expiration \_\_\_in. Chest at forced inspiration \_\_\_in. Abdomen fully relaxed \_\_\_\_\_in.

15. BLOOD PRESSURE: All readings to be taken in sitting position. If first Reading is 140/90 or over make two additional observations at intervals. Record all readings.

	Systolic	Diastolic (fifth phase)
1st reading	_____	_____
2nd reading	_____	_____
3rd reading	_____	_____

16. Temperature      17. Pulse Rate      **IF PULSE IS IRREGULAR, complete exercise test**

On inquiry and examination is there evidence of:

	YES	NO
18. Present of past disease or abnormalities of:		
a. Brain, nervous system? (Test reflexes; coordination).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Eye, ears, nose, throat, teeth, gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Thyroid, lymph glands or endocrine system? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Lungs or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdominal organs or digestive tract? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary organs? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Skin, skeletal structure or muscular system? .....	<input type="checkbox"/>	<input type="checkbox"/>
19. Hernia? (If yes, describe.) .....	<input type="checkbox"/>	<input type="checkbox"/>
20. Varicose veins or ulcers? .....	<input type="checkbox"/>	<input type="checkbox"/>
21. Arteriosclerosis; other peripheral vascular disease? .	<input type="checkbox"/>	<input type="checkbox"/>
22. Present or past disease or abnormalities of heart of blood vessels? .....	<input type="checkbox"/>	<input type="checkbox"/>
23. a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Is there hypertrophy? (If yes, state degree.) .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Is there a murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>
Type:                      Quality:                      Intensity:                      Location:		
<input type="checkbox"/> Systolic <input type="checkbox"/> Blowing <input type="checkbox"/> Faint <input type="checkbox"/> Apical		
<input type="checkbox"/> Diastolic <input type="checkbox"/> Rough <input type="checkbox"/> Moderate <input type="checkbox"/> Pulmonic		
<input type="checkbox"/> Presystolic <input type="checkbox"/> Musical <input type="checkbox"/> Loud <input type="checkbox"/> Aortic		
d. Is murmur constant? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Is murmur transmitted? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____		

24. Urinalysis      Specific Gravity      Albumin      Sugar

<b>(To be Completed By examiner In all cases)</b>				Y	N
a. Are you satisfied specimen is authentic? .....				<input type="checkbox"/>	<input type="checkbox"/>
b. Are you forwarding specimen to Administrative Office? .....				<input type="checkbox"/>	<input type="checkbox"/>

NOTE:

**Specimen should be sent to**

**Administrative Office with each examination.**

25. Have you any pertinent information affecting proposed insured not brought out above? .....

### DETAILS

EXERCISE TEST	Pulse Rate	Irregularities		Murmur	
		No. per Min	Present	Present	Absent
50 vigorous hops					
<b>BEFORE EXERCISE</b>					
<b>IMMEDIATELY AFTER</b>					
<b>3 MINUTES AFTER</b>					

PLEASE RECORD FINDINGS:

USING FOLLOWING SYMBOLS:

Position of apex beat .....

(\_\_\_Ins. or \_\_\_cms. from

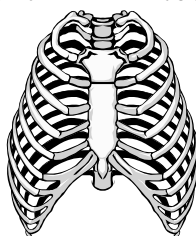
Midsternum in \_\_\_\_\_interspace)

Murmur:

Area of distribution .....

Point of greatest intensity.....

Direction of transmission..... →



Signature of Medical Examiner \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_



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**NOTICE AND CONSENT TO HIV-RELATED TESTING**

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

**PRE-TESTING CONSIDERATIONS**

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

**MEANING OF POSITIVE TEST RESULT**

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. Positive HIV antibody test results 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 charges may be necessary.

**CONFIDENTIALITY OF TEST RESULTS**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover the results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

**NOTIFICATION OF TEST RESULTS**

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result	Address
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If you do not wish to know the results of the test, initial here: \_\_\_\_\_. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

**CONSENT**

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluid, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive. I understand that this consent can be withdrawn at any time prior to the drawing of the blood and/or other bodily fluid for testing.

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.

Name of Proposed Insured (Please Print or Type)	Address	
Signature of Proposed Insured or Parent/Guardian		Date

## HIV Antibody Test Information

### AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug user, hemophiliacs, and persons who have had sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant change of developing AIDS over the next 10 years.

**What are the Symptoms?** Most people infected with AIDS virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever including 'nights sweats'
- Weight loss for no known reason
- Swollen lymph glands in the neck, underarm or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth.

These symptoms are also symptoms of many other illnesses. They may be symptoms of AIDS only if they are not explained by other illness. Anyone with these symptoms for more than two weeks should see a doctor.

### The HIV Antibody Test

Before you consent to testing, please read the following important information:

- 'ELISA' test** means an enzyme-linked immunosorbent assay serologic test which has been licensed by the federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus.
- 'Positive ELISA test'** means an ELISA test performed in accordance with the manufacturer's specification which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.
- 'Western Blot Assay'** means an assay which uses reagents consisting of HIV antigens separated by polyacrylamide gel electrophoresis and then transferred to nitrocellulose paper to detect antibodies to the human immunodeficiency virus.
- Reactive 'Western Blot Assay'** means an assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the 'Western Blot Assay' reagents and laboratory apparatus.
- 'HIV antibody test'** means an ELISA test or a Western Blot Assay or both.

**Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

**Positive Test Result.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.

**Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

- False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
- False negative:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive result to develop after a person is infected.

**Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known by others. A negative result may create a false sense of security.

**Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

### AIDS Counseling Facilities:

AHF Magic Clinic  
411 30<sup>th</sup> Street, Suite 200  
Oakland, CA 94609  
(510) 628-0949

San Francisco AIDS Foundation  
995 Market Street  
San Francisco, CA 94103  
(415) 863-2437

AIDS Health Project  
1930 Market Street  
San Francisco, CA 94102  
(415) 476-3902

AIDS Project – Los Angeles  
3550 Wilshire Blvd  
Los Angeles, CA 90010  
(213) 201-1600

AIDS Hotline  
U.S. Public Health Service  
(800) 342-AIDS

San Joaquin AIDS Foundation  
4330 N. Pershing Avenue, #B-3  
Stockton, CA 95207  
(209) 476-8533

The Health Trust Health Connection  
1701-A South Bascom Avenue, Suite  
416  
Campbell, CA 95008  
(408) 961-9850

California AIDS Hotline (in English and  
Spanish)  
(800) 367-AIDS  
TDD for the Deaf: (888) 225-AIDS