# Medical Examination Form

- ☐ *ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401*
- ☐ *Security-Connecticut Life Insurance Company, 20 Security Drive, Avon, CT 06001-4237*
- ☐ *Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203-5699*
- ☐ *Southland Life Insurance Company, Atlanta, GA–Administrative Office: 1290 Broadway, Denver, CO 80203-5699*

1. Name of Proposed Insured ____________ Date of birth ________ Social Security No ________
2. Name, address and telephone number of personal physician or clinic ____________

____________

Date last consulted ________ Reason for, and results of consultation ____________

**Record Question Number, Condition, Diagnosis, and Dates/Duration of Condition or Treatment and Names and Addresses of All Doctors and Hospitals.**

3. In the past 10 years, have you ever been treated for or been diagnosed as having:
   a. Dizziness, fainting, convulsions, optic neuritis, headache, paralysis, stroke, mental or nervous disorder? ☐ Yes ☐ No
   b. Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, emphysema, tuberculosis, or chronic respiratory disorder? ☐ Yes ☐ No
   c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, diverticulitis, or other disorder of the stomach, intestine, liver or gall bladder? ☐ Yes ☐ No
   e. Sugar, albumin, blood or pus in urine, venereal disease, nephritis, stone, or other disorder of kidney, bladder, breasts, prostate or reproductive organs? ☐ Yes ☐ No
   f. Diabetes, thyroid or other endocrine disorder? ☐ Yes ☐ No
   g. Rheumatism, arthritis, or disorder of the muscles or bones? ☐ Yes ☐ No
   h. Disorder of skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   i. Allergies, anemia or other disorder of the blood? ☐ Yes ☐ No
4. Have you:
   a. Experienced any symptom(s) for which you have not yet consulted a health care provider? ☐ Yes ☐ No
   b. Had any operation(s) in the past 10 years? ☐ Yes ☐ No
   c. Been advised to have operation(s) or diagnostic tests not yet performed in the last 10 years? ☐ Yes ☐ No
   d. Had an electrocardiogram, x-ray, or other diagnostic test in the last five years? ☐ Yes ☐ No
   e. Sought or been advised to seek help or treatment for an alcoholic habit? ☐ Yes ☐ No
   f. In the last 10 years been confined for observation, care, or treatment in a hospital or other health care facility? ☐ Yes ☐ No
   g. In the last five years consulted any health care provider(s) not already identified for any reason including routine physical examination? ☐ Yes ☐ No
5. Are you:
   a. Presently taking any medication(s), including non-prescription/over the counter medication or presently under the care of a member of the medical profession for any condition? ☐ Yes ☐ No
   b. Currently using, or have you ever received treatment or counseling for the use of: ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, opium derivatives, or other drugs of abuse? ☐ Yes ☐ No
6. Family history of Proposed Insured:

| | *Age if living* | *Age at death* | *Current health or cause of death* |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| Sisters | | | |

**I have read the statements given in the examination and affirm that they are complete and true to the best of my knowledge and belief.**

Signed at *(city and state)* ____________ Date *(month, day, year)* ________

Signature of examiner ____________ Signature of Proposed Insured ____________

*(parent or legal guardian if Proposed Insured is under 15)*

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# Medical Examiner's Report

*Give further details needed for clarification in space at bottom of form.*

1. a. How long have you known the Proposed Insured? ______

   b. Are you related to him/her or to the agent? ☐ Yes ☐ No

2. a. Exact weight ____ lbs. b. Exact height ____ ft. ____ in.

   c. Weight change in last year ____ lbs.

   d. Girth (males only) Chest at forced expiration ____ in.

   Forced expiration ____ in. Abdomen ____ in.

3. a. Blood pressure: (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 .................... ____ per minute

   c. Irregularities ______

4. Have the blood and urine specimens been sent? .............................................. ☐ Yes ☐ No

   a. Lab ticket number: ______

   b. Name of Lab: ______

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

6. *For females only.*

   a. Was client menstruating at time the urine specimen was voided? ............................ ☐ Yes ☐ No

   b. Is client pregnant? ................................ ☐ Yes ☐ No

7. Does the client currently use or have they 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: ______

8. a. 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

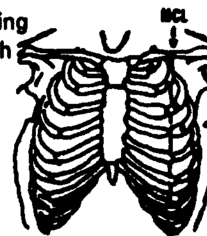
   d. Are there any heart murmurs? .............. ☐ Yes ☐ No

   If yes, diagnosis: ☐ Functional ☐ Organic

   Type: ______

Please indicate:

| *Timing* | *Intensity* | *Quality* |
|---|---|---|
| ☐ Systolic | ☐ Faint | ☐ Soft |
| ☐ Presystolic | ☐ Moderate | ☐ Blowing |
| ☐ Diastolic | ☐ Loud | ☐ Rough |




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

   e. Is 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" in #12.)*

10. a. Is there any evidence of dementia? .......... ☐ Yes ☐ No

    b. Is there any evidence the client 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 applicant? .... ☐ Yes ☐ No

12. Remarks and Explanations

______

TO THE MEDICAL EXAMINER: Any erasures or alterations in this report should be initialed by you.

12. Examination was made at: ☐ Residence ☐ Business ☐ My office

    ☐ Board Certified ☐ Board Eligible

13. Signature of Examiner ______

    a. Address ______

    b. Phone number ______ c. Social Security Number or Tax ID Number ______

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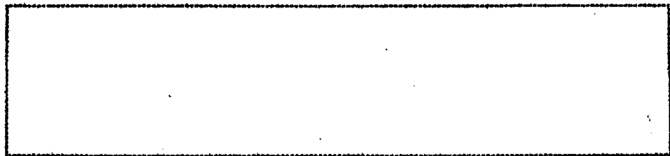

INSURANCE COMPANY

***NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING***

## THE HIV ANTIBODY TEST

**To evaluate your insurability, the Insurer named above has requested that you provide a specimen sample of your blood, urine or saliva 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. A series of tests will be performed by a licensed laboratory through medically accepted procedure.**

**The HIV antibody test is extremely accurate. However, like any medical test, it is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when infection occurred within the previous 3-6 months prior to the test.**

## MEANING OF TEST RESULTS

**Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.**

**A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.**

## COUNSELING

**Many public health organizations have recommended that before taking an AIDS-related test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling at your own expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have any questions or concerns, you may wish to consult your own physician or health care provider. A list of counseling resources is provided for your information.**

## NOTIFICATION OF TEST RESULTS

**If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.**

**Name of Physician:**____________________________**Address**____________________________________

## CONFIDENTIALITY OF TEST RESULTS

**All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results 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 need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include 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. No other disclosure will be made of the results except as required by law.**

## CONSENT

**I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and disclosure of the test results as described above.**

**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)** **Date**

______________________________________ ________________________
**Signature of Proposed Insured** **Date**