

**SHELTER LIFE INSURANCE COMPANY, 1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001**

Name of Proposed Insured:	Birthdate		Sex	Name of Agent:
	Mo.	Day		

Address of Proposed Insured:

MEDICAL HISTORY (to be recorded by medical examiner):	YES	NO	PLEASE GIVE FULL DETAILS
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So far as you know and believe—

Dates, severity, treatment, duration, outcome; names, addresses of physicians, hospitals or clinics.

1. Have you ever had any physical disability or impairment?  YES  NO
2. Is your health impaired at present?  YES  NO
3. Is any medication being taken? (If yes, list drugs and reason)  YES  NO
4. Have you ever had any indication or diagnosis of:
  - a. Disease or disorder of heart, blood or blood vessels; high blood pressure, or has heart or blood pressure medication ever been advised or taken?  YES  NO
    - (1) Rheumatic fever or heart murmur?  YES  NO
    - (2) Coronary artery disease, chest pain or discomfort?  YES  NO
    - (3) Shortness of breath, abnormal heart rate or rhythm?  YES  NO
  - b. Disease or disorder of nose, sinuses, throat?  YES  NO
  - c. Disease or disorder of lungs or bronchi?  YES  NO
    - (1) Tuberculosis or exposed to tuberculosis?  YES  NO
    - (2) Pleurisy, chronic cough or asthma?  YES  NO
  - d. Disease or disorder of esophagus, stomach, intestinal tract?  YES  NO
    - (1) Indigestion, diarrhea, abdominal pain, ulcer, intestinal bleeding or hemorrhoids?  YES  NO
    - (2) Jaundice, liver or gall bladder disease?  YES  NO
  - e. Disease or disorder of kidneys, ureters, urethra, bladder?  YES  NO
    - (1) Sugar, albumin, pus, blood or casts in the urine?  YES  NO
  - f. Disease or disorder of prostate or testicles? (Male)  YES  NO
  - g. Disease or disorder of breasts, uterus, cervix, tubes, ovaries; abnormal menstruation or pregnancies; present pregnancy? (Female)  YES  NO
  - h. Disease or disorder of brain or nervous system?  YES  NO
    - (1) Headache, dizziness or unconsciousness?  YES  NO
    - (2) Mental illness, seizure, convulsion, epilepsy, paralysis?  YES  NO
    - (3) Neuralgia or neuritis?  YES  NO
  - i. Diabetes; thyroid or other glandular disorder?  YES  NO
  - j. Disease or disorder of skin, lymph glands, muscles, bones or joints; arthritis; gout; back disorder?  YES  NO
  - k. Disease or disorder of eye or ear; impaired sight or hearing?  YES  NO
  - l. Tumor, cancer, syphilis?  YES  NO
  - m. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  YES  NO
5. Have you ever (had):
  - a. Weight gain  or loss  in past year? (If yes, list amount, reason)  YES  NO
  - b. Used alcohol, marijuana, cocaine or other drugs? (If yes, list amount, frequency and date(s) used)  YES  NO
  - c. Used tobacco in any form? (If yes, list form of usage and date last used.)  YES  NO
  - d. Any condition or treatment not specified above which necessitated blood tests, X-rays, electrocardiograms, operations, hospital confinement or examination or treatment by a physician, practitioner, hospital, clinic or institution?  YES  NO
  - e. Military service rejection or discharge for medical reasons?  YES  NO
  - f. A history of parents, brothers or sisters who experienced:
    - (1) Diabetes, heart or kidney disease, high blood pressure?  YES  NO
    - (2) Death before age 60? (Relationship, age, cause of death?)  YES  NO

6. Name and address of personal physician?	a. Date last seen? ,	b. For what reason?
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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.

WITNESS

Medical Examiner

SIGNED

Proposed Insured

DATED

**EXAMINATION OF:**  
(List full name)

**PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN "DETAILS" SPACE BELOW**

7. Height		8. Weight		9. Girth—Chest		10. Girth—
Ft.	In.	Present	1 Yr. Ago	Insp.	Exp.	Abdomen
11. Temperature		12. Pulse Rate		<b>IF PULSE IS IRREGULAR complete exercise test, question 18. f. below.</b>		
13. Blood Pressure		Systolic	Diastolic (Phase V)	<b>IF BLOOD PRESSURE IS ABNORMAL, record additional reading after 5 minutes.</b>		
1st Reading						
Additional						

19. **Urinalysis** - Forward specimen to our laboratory in container provided only when:
- a. Amount applied for exceeds \$100,000, or
  - b. There is history of cardiovascular or urinary system abnormality or diabetes, or
  - c. Requested to do so by agent and/or Home Office.
20. Are you forwarding specimen to our lab? .....  YES  NO
21. Do you have any pertinent information about the proposed insured not brought out in this exam? .....  YES  NO

- On inquiry and examination, is there evidence of-- YES NO
14. Present or past diseases or abnormalities of:
- a. Brain, nervous system? (Test reflexes; coordination) ..
  - b. Ears, nose, throat, teeth, gums? .....
  - c. Thyroid or lymph glands? .....
  - d. Lungs or respiratory system? .....
  - e. Abdominal organs? .....
  - f. Genito-urinary organs? .....
  - g. Skin or skeletal structure? .....
15. Hernia? (If yes describe) .....
16. Varicose veins, phlebitis or ulcers? .....
17. Arteriosclerosis; other peripheral vascular disease? .....
18. Present or past diseases or abnormalities of heart of blood vessels? (If yes, complete questions 18. a. through 18. g.) ..

- REQUIRED WHEN QUESTION 18 IS ANSWERED "YES"**
- a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis? .....
  - b. Is there hypertrophy? (If yes, state degree) .....
  - c. Is there a murmur? .....
- |                                      |                                  |                                   |                                   |
|--------------------------------------|----------------------------------|-----------------------------------|-----------------------------------|
| Type:                                | Quality:                         | Intensity:                        | Location:                         |
| <input type="checkbox"/> Systolic    | <input type="checkbox"/> Soft    | <input type="checkbox"/> Faint    | <input type="checkbox"/> Apex     |
| <input type="checkbox"/> Diastolic   | <input type="checkbox"/> Rough   | <input type="checkbox"/> Moderate | <input type="checkbox"/> Base     |
| <input type="checkbox"/> Presystolic | <input type="checkbox"/> Blowing | <input type="checkbox"/> Loud     | <input type="checkbox"/> Pulmonic |
- d. Is murmur constant? .....
  - e. Is murmur transmitted? .....
- If yes, where? \_\_\_\_\_

**NOTE:** Do not perform exercise test if in your opinion it is inadvisable to do so.

f. EXERCISE TEST-- 50 vigorous hops	Blood	Pulse	Irregularities		Murmur	
	Pressure	Rate	No.	Per Minute	Present	Absent
BEFORE EXERCISE						
IMMEDIATELY AFTER						
3 MINUTES AFTER						

g. PLEASE RECORD FINDINGS, USING FOLLOWING SYMBOLS:

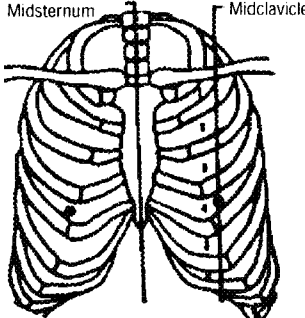
Position of apex beat ..... X  
( \_\_\_ ins. or \_\_\_ cms. from midsternum in \_\_\_ interspace)

Murmur:

Area of distribution .....

Point of greatest intensity .. O

Direction of transmission ... →



**DETAILS**

**Physician Examiner:**

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

**Paramedical Examiner:**

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Name of Paramedical Company \_\_\_\_\_



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