PART-2 APPLICATION for INSURANCE – Medical History
SHENANDOAH LIFE INSURANCE COMPANY OF ROANOKE, VIRGINIA

Proposed Insured: ______ First name / Middle Initial / Last Name	Soc. Sec. No.:	Birth Date:

1. a. Name and address of your personal physician: *(If none, so state)* ______
   b. Date and reason last consulted: ______
   c. What treatment was given or medication prescribed? ______

2. DURING THE PAST 10 YEARS (7 YEARS IN MARYLAND) HAVE YOU: *Yes* *No*
   a. Had a heart attack; high blood pressure; stroke or other disorder of the heart or blood vessels? .... ☐ ☐
   b. Had cancer; tumor; cyst; leukemia; lymph gland, thyroid, or blood abnormality? .... ☐ ☐
   c. Had diabetes or other endocrine disorder; sugar, albumin or blood in urine; stone or other disorder of kidney, bladder or reproductive organs or breasts; or complications of pregnancy? .... ☐ ☐
   d. Had a lung or chronic respiratory disorder; asthma; emphysema; pneumonia, tuberculosis or sleep apnea? .... ☐ ☐
   e. Had intestinal bleeding; ulcer; hernia; hemorrhoids; colitis; or other disorder of esophagus, stomach, liver, intestine or gallbladder? .... ☐ ☐
   f. Had syphilis, gonorrhea, genital herpes, genital warts, hepatitis, or any other STD? .... ☐ ☐
   g. Been diagnosed or treated by a member of the medical profession for AIDS? .... ☐ ☐
   h. Tested positive for antibodies to the AIDS virus? .... ☐ ☐
   i. Had a brain, mental or nervous disorder; fainting; convulsions; paralysis; depression; or attempted suicide? .... ☐ ☐
   j. Had arthritis; gout; loss of limb or deformity; disorder of bone, joint, muscle, back or spine; or skin disorder? .... ☐ ☐
   k. Had a disorder of eyes, ears, nose or throat? .... ☐ ☐
   l. Received advice or treatment or been convicted for the use of alcohol or drugs or attended Alcoholics Anonymous? .... ☐ ☐

3. DURING THE PAST 5 YEARS HAVE YOU: *Yes* *No*
   a. Had any serious illness, disease or injury not mentioned above? .... ☐ ☐
   b. Been advised to take or are you now taking treatment or medication? .... ☐ ☐
   c. Had any diagnostic test, such as an electrocardiogram, x-ray, or blood study? .... ☐ ☐
   d. Had surgery? .... ☐ ☐
   e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? .... ☐ ☐
   f. Had a checkup or consultation or been a patient in a hospital, institution, clinic, or sanitarium or other medical facility? .... ☐ ☐

4. HAVE YOU: *Yes* *No*
   Used amphetamines, barbiturates, cocaine, narcotics, marijuana or other depressant, excitant or hallucinatory drugs unless administered on the advice of a physician? .... ☐ ☐

5. Do you smoke cigarettes?
   a. Now ☐ In the past ☐ Never ☐
      Number of years smoking ______
      Packs smoked per day ______
      If smoked in the past, date stopped: ______
   b. Do you use tobacco in other forms?
      ☐ Yes ☐ No If yes, type ______
      Amt. per day ______

6. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? .... Yes ☐ No [

	Age if Living?	Cause of Death?	Age a Death'
Father			
Mother			
Brothers and Sisters No. Living ______ No. Dead ______			

DETAILS OF "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnos dates, duration and names and addresses of all attending physicians and medical facilities.)

I declare that the statements and answers above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at ______ this ______ day of ______, ______

Witness ______ M.D. ______
(Signature of Medical Examiner) *(Signature of Proposed Insured, or Signature of Parent or Guardian if Proposed Insured is a Minor)*

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MEDICAL EXAMINER'S REPORT *(Not part of the Application)*

7. a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
___ft. ___in.	_____ lbs.	_____ in.	_____ in.	_____ in.

b. Did you weigh? .. ☐ Yes ☐ No Did you measure? .... ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? .... ☐ Yes ☐ No

8. Blood Pressure (If initial blood pressure elevated, retake later in exam.)

	1	2	3
Systolic			
Diastolic 5th phase			

9. Pulse:

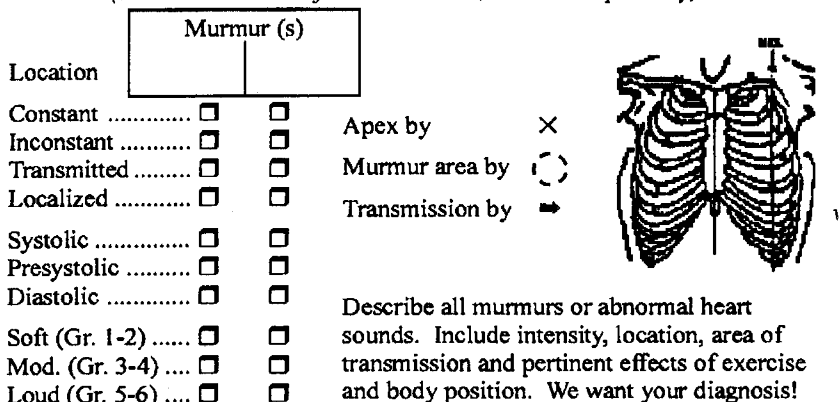
	At Rest	*After Exercise*	*3 Minutes Later*
Rate:			
Irregularities per min.			

10. Heart: Is there any:

Enlargement .... ☐ Yes ☐ No Dyspnea .... ☐ Yes ☐ No

Murmur(s) .... ☐ Yes ☐ No Edema .... ☐ Yes ☐ No

(describe below — if more than one, describe separately)



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

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? *(If vision or hearing markedly impaired, indicate degree and correction.)*	☐	☐
b. Skin (incl. scars); lymph nodes; varicose veins?	☐	☐
c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
i. Retinopathy (Indicate K-W)	☐	☐
j. Peripheral pulses (decreased bruits)?	☐	☐
12. a. Are there any hernias?	☐	☐
b. Any hemorrhoids?	☐	☐
13. Are you aware of additional medical history? *(A confidential report may be sent to the Medical Director)*	☐	☐
14. Are you alone with proposed insured and unrelated to both proposed insured and agent?	☐	☐

We rely on your clinical thoroughness to hel
us classify the risk from an insurance point c
view. Please make sure all questions are answered and record detail of "yes" and pertinent "no" answers below.

Dip Stick Urinalysis

Sugar?	*Albumin?*

Mail Specimen to our lab in all cases.

Check (✓) ☐ Exam for Personal Insurance
☐ Exam for Group Insurance
Group Policy # ________

Name of Agent ________

I certify that I have carefully examined ____________________ of ____________________
(City and Street Address)

☐ my office
☐ place of business this ________ day of ____________, ________ at ____________ A. P.
☐ home

Signature of Examiner ______________________________ Examiner's Name and Address
Please Print – Or Use Stamp

$
Fee
Soc. Sec. No.

Or Fed. I.D.

Review report carefully for completeness of all sections then mail directly to the Medical Director at the Home Office of the Company.

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

To evaluate your eligibility for insurance or insurance benefits, it is requested that you consent to be tested for the AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as allowed by law or as stated below.

MEANING OF TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies of the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could 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 changes may be necessary.

RELEASE OF RESULTS

The results of this test may be released to the following:

1. the proposed insured;
2. the person legally authorized to consent to the test;
3. a licensed physician, medical practitioner, or other person designated by the proposed insured;
4. an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover 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 proposed insured;
5. a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;
6. persons who have the responsibility to make underwriting decisions on behalf of the insurer; or
7. insurer's legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

The insurer may contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results.

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

______________________________ Date Signed

X______________________________ Signature of **Proposed Insured**, or Parent/Guardian, if applicable