



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 _____

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

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

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)

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.

Systolic	1st	2nd	3rd	4th
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

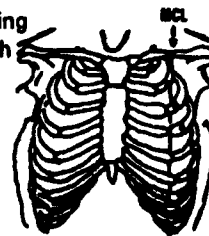
If yes, diagnosis: Functional Organic

Type:

Please indicate:

- | | | |
|--------------------------------------|-----------------------------------|----------------------------------|
| Timing | Intensity | Quality |
| <input type="checkbox"/> Systolic | <input type="checkbox"/> Faint | <input type="checkbox"/> Soft |
| <input type="checkbox"/> Presystolic | <input type="checkbox"/> Moderate | <input type="checkbox"/> Blowing |
| <input type="checkbox"/> Diastolic | <input type="checkbox"/> Loud | <input type="checkbox"/> 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



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