Application for Insurance - Medical History

Standard Insurance Company • Individual Division
1100 SW Sixth Avenue • Portland, OR 97204-1093

1. Proposed Insured (print)_____
2. Birthdate: _____ 3. Height: _____ft _____in.
4. Weight: _____ lbs., Weight Loss in Last Year: _____ lbs.
5. a. What is the name, address and phone number of your physician or health care facility? ☐ Check if none.
   b. When did you last see your physician or health care facility?
   c. Give reason seen and results.
   d. Describe any treatment or medication prescribed.
6. In the last 10 years have you had, been told you had, been treated or seen by a medical practitioner for, or been diagnosed as having:

	Yes	No
a. Disorder of the eye, ear, nose or throat?	☐	☐
b. Anxiety, depression, nervousness or stress; or other mental, emotional or psychiatric disorder?	☐	☐
c. Stroke, dizziness, fainting, convulsion, recurrent headaches, paralysis or mental deficiency; or any other brain or nervous system disorder?	☐	☐
d. Fibromyalgia, chronic fatigue, chronic fatigue syndrome or Epstein-Barr virus?	☐	☐
e. Asthma, bronchitis, emphysema or pneumonia; or other lung or respiratory disorder?	☐	☐
f. High blood pressure, chest pain or heart attack?	☐	☐
g. Irregular heart beat, anemia or murmur; or other disorder of heart, blood or blood vessels?	☐	☐
h. Colitis, bleeding or recurrent indigestion; or other disorder of liver, intestines, esophagus, stomach or pancreas?	☐	☐
i. Diabetes; sugar, albumin, blood or pus in urine; or any unexplained fevers?	☐	☐
j. Disorder of kidney, bladder, prostate, breasts, menstrual cycle or reproductive organs?	☐	☐
k. Disorder of skin, lymph nodes, or thyroid?	☐	☐
l. Cyst, growth, polyp, tumor, leukemia or cancer?	☐	☐
m. Any type of spinal, neck or back disorder or injury, including sprain, strain or disc disorder?	☐	☐
n. Neuritis, rheumatism or arthritis; or other disorder or injury of muscle, nerve, bone or joint?	☐	☐
o. Miscarriage, C-section or complication of pregnancy?	☐	☐
7. Are you pregnant?	☐	☐
8. Other than as stated in other answers, have you within the last 5 years:		
a. Been hospitalized or been seen by a physician, chiropractor, counselor, psychiatrist, therapist or other medical practitioner?	☐	☐
b. Had an EKG or blood test; or other medical procedure, study or test?	☐	☐
c. Been advised to have any medical test, surgery or hospitalization, that was not completed?	☐	☐
9. Do you now take, or in the last 3 years have you taken any prescription medicine?	☐	☐

Remarks Area. Explain all YES answers. Give the date, reason, diagnosis, duration and severity; treatment and results; and the names and addresses of all physicians and medical facilities. Use other side if necessary.

Question Number	

	Yes	No
10. In the last 3 years have you had any symptom or disorder lasting more than 30 days for which you have taken any non-prescription medication or natural or herbal supplement?	☐	☐
11. In the last 3 years have you had any physical or mental condition or symptom that has not been treated or diagnosed?	☐	☐
12. In the last 10 years have you:		
a. Used cocaine, barbiturates, amphetamines, narcotics or hallucinogens; or any other controlled or illegal substance?	☐	☐
b. Been cited or arrested for driving under the influence of a controlled substance, drug or alcohol?	☐	☐
13. Do you drink alcoholic beverages? If no, give the month and year last used: _____. If yes, give amount per week below. wine _____ glasses; beer _____ bottles; liquor _____ drinks	☐	☐
14. Have you used tobacco or nicotine in any form in the last 5 years? If yes, circle the type(s) below and complete table:	☐	☐

	HOW LONG USED	AMT PER DAY	DATE LAST USED
a. cigarettes			
b. pipe, cigar			
c. smokeless			
d. gum, patch, other			

I REPRESENT that all answers to the above questions are correctly recorded, and are complete and true to the best of my knowledge and belief. I understand that Standard Insurance Company will rely on this information in considering my eligibility for insurance and my eligibility for various premium rates. I agree that this Application for Insurance - Medical History shall become part of any contract of insurance based on such application.

Signature of Proposed Insured _____ Date _____ City & State where signed _____

Signature of Parent or Guardian if Proposed Insured is under actual age 18 _____ Signature of Medical Examiner or Agent _____

NOTE: A person commits a fraudulent act when that person knowingly files an application for insurance which either contains materially false information or conceals material information with intent to mislead.

STANDARD INSURANCE COMPANY – MEDICAL EXAMINER'S REPORT – TO BE FILLED OUT IN PRIVATE

	Yes	No
1. Was the person being examined able to speak and understand English? If no, give details.	☐	☐
2. Was a third person present during the exam? If yes, explain.	☐	☐
3. Are you examining proposed insured concurrently for another company; or have you (your company) examined the proposed insured in the last six months?	☐	☐
4. Does person appear unhealthy or other than stated age? If yes, explain.	☐	☐
5. Do you observe any obvious physical or mental impairments? If yes, explain.	☐	☐
6. Did you weigh and measure as shown below? If no, explain.	☐	☐

7. Height: _____ ft. _____ in. (in shoes) Weight: _____ pounds (clothed)

8. For males only: Chest: _____ in. Chest: _____ in. Waist: _____ in.
(full inspiration) (forced expiration) (relaxed at umbilicus)

9. BLOOD PRESSURE: Systolic: _____ _____ _____
(Recheck if systolic exceeds 140 or diastolic exceeds 90.) Diastolic: _____ _____ _____
(5th Phase)

10. PULSE:

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

*Note: Complete after exercise and later only if abnormal rate or irregularity is detected at rest.

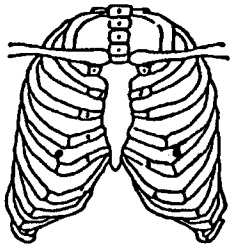
11. HEART:

	Yes	No
(a) Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder?	☐	☐
(b) Is heart enlarged? If yes, describe.	☐	☐
(c) Is murmur present? If yes, complete 11d and e.	☐	☐

(d) Murmur is: ☐ Constant ☐ Transmitted ☐ Pan-systolic ☐ Apical Loudness:
☐ Inconstant ☐ Localized ☐ Ejection ☐ Aortic Grade __/ 6
☐ Diastolic ☐ Other

After exercise: ☐ Unchanged ☐ Increased
☐ Decreased ☐ Absent

Show Location Of:
Apex by: X
Area of murmur by: ◌
Point of greatest intensity by: O
Transmission by: →



(e) Your impression of murmur? _____

12 Is there any indication of abnormality of the following? (circle items and give details):	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (include scars), lymph nodes, blood vessels?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis and mental status)?	☐	☐
(d) Respiratory system, chest (include scars)?	☐	☐
(e) Digestive system, abdomen (include scars)?	☐	☐
(f) Endocrine system (include thyroid)?	☐	☐
(g) Musculoskeletal system (include spine, joints, deformities)?	☐	☐

NOTE: Breast, prostate, genital and/or rectal exam is NOT requested.

13. Are you aware of additional medical history?	☐	☐

Details - Please give full details of all yes answers, exam findings and opinions; or to explain YES answers on other side.

Item Number	

14. If a urine specimen is required; refer to #16.
Was urine specimen sent? ☐ Yes ☐ No

15. If required, are you sending:
EKG ☐ Yes ☐ No
Blood Specimen (LabOne) ☐ Yes ☐ No

16. SEND BLOOD SPECIMEN AND/OR URINE TO:
LabOne
P.O. Box 2035
Shawnee Mission, KS 66201-9906

EXAMINER SHOULD MAIL THIS COMPLETED FORM DIRECT TO:

STANDARD INSURANCE CO.
INDIVIDUAL UNDERWRITING - P4B
P.O. BOX 5640
PORTLAND, OR 97228-9921

I certify that I made this examination at: _____ ☐ A.M. ☐ P.M. on: Month _____ Day _____ Year_____
in: ☐ My office ☐ Individual's office ☐ Individual's home ☐ Other _____

Examiner's signature: _____

Examiner's address: _____ ZIP _____

GIVE NAME OF AGENT ORDERING THIS EXAMINATION: _____