

Paramed Exam Form

American United Life Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 368
Indianapolis, IN 46206-0368
(317) 285-1877

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a ONEAMERICA® company
101 North 10th Street
Fargo, ND 58102
(701) 297-5700

The State Life Insurance Company
a ONEAMERICA® company
P.O. Box 6062
Indianapolis, IN 46206
(317) 285-2300



ANSWERS MADE TO THE MEDICAL EXAMINER

Please print or type. Use black ink. Do not use dashes or ditto marks.

_____ <i>Full Name of Proposed Insured</i>	____/____/____ <i>Date of Birth</i>	____-____-____ <i>Social Security Number</i>
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Name and Address of Personal Physician (If none, state "None:") _____

Date, reason and results of Proposed Insured's last doctor visit or consultation. _____

1. Is the Proposed Insured now under observation, receiving treatment or taking medication prescribed by a member of the medical profession?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. In the past 10 years, has the Proposed Insured ever been diagnosed as having, been treated for or ever had (<i>Circle Applicable Items</i>):		
a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Cancer, tumors, Kaposi's sarcoma, disorder of the skin, swelling of the lymph glands, fever of unknown origin, night sweats, lupus or collagen disorder, arthritis or any bone or muscle disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, Alzheimer's, senile dementia, nervous or mental disorder including anxiety, depression, attempted suicide or a suicidal gesture?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Shortness of breath, persistent hoarseness or cough, blood spitting, pneumocystis carinii pneumonia, bronchitis, asthma, emphysema, tuberculosis, allergies, sleep apnea, or other chronic respiratory system disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Diabetes, thyroid or other endocrine disorder, elevated blood sugar, albumin, blood, sugar or pus in the urine, stone or other disease of kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of the stomach, intestine, gallbladder or spleen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Hepatitis, cirrhosis or other disorder of the liver or pancreas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Anemia, bleeding tendency or other disorder of the blood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Disorder of eyes, ears, nose or throat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Deformity, lameness or amputation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k. Any indication, diagnosis or treatment of alcohol or drug dependency, abuse or reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. Is the Proposed Insured pregnant? If yes, due date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Within the past 5 years, has the Proposed Insured (<i>Circle Applicable Items</i>):		
a. Had a checkup, consultation, illness, injury or surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Had a diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Been a patient in a hospital, clinic, sanitarium, extended care facility, nursing home, hospice or other medical facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed or where results are still pending or have a doctor's appointment scheduled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Had any condition resulting in over 10 consecutive days of time lost from work or required assistance for a period longer than one week pertaining to activities of daily living; such as bathing, dressing, continence, eating, toileting and transferring?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Requested or received home nursing or home healthcare, a pension, benefits or payment because of injury, sickness or disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Record details of "Yes" answers. IDENTIFY QUESTION NUMBER. Include all dates, diagnoses, names and addresses of all attending physicians and medical facilities. (<i>Enter additional details on page 2.</i>)		

Details of "Yes" answers continued:

5. Family History:

	Age if still Living	Age at Death	State of Health/ Cause of Death	Cancer (Any type)	Heart disease, stroke or circulatory disorder	Diabetes
Mother _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Siblings _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Nicotine and/or Tobacco Use:

a. Never Present Former

b. Type of nicotine or tobacco used: _____

c. When did the Proposed Insured quit using all forms of nicotine or tobacco? (month/year) _____

7. Answer for the applicable state where this form is signed:

Arizona, Connecticut, New Jersey, North Dakota, Texas or West Virginia:

Has the Proposed Insured been diagnosed or treated by a member of the medical profession as having AIDS? Yes No

Answer if state not listed above:

Has the Proposed Insured been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession, or had a positive test result confirming presence of the AIDS virus (Human Immunodeficiency Virus (HIV), Human T-cell Lymphotropic Virus - Type III (HTLV-III)? Yes No

I have read the statements and answers made above. They are, to the best of my knowledge and belief, true, complete and correctly recorded. This supplement will become a part of my application for insurance and will be a part of the basis of any insurance issued.

Signed at _____, on _____
City State Date

Signature of Proposed Insured Witness Signature of Representative

**Informed
Consent**

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P.O. Box 406
Indianapolis, IN 46206
(317) 285-2300*



EXAMINER _____
ADDRESS _____

HIV ANTIBODY TESTING CONSENT FORM

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test, because many abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, 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 the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

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. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-752-2437 (AIDS).

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or entity:

Name: _____
Address: _____

Informed Consent

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured

Birthdate

State of Residence

Date Signed by Proposed Insured

Signature of Witness