



STATE FARM INSURANCE COMPANIES

HOME OFFICES: BLOOMINGTON, ILLINOIS 61710-0001

- STATE FARM LIFE INSURANCE COMPANY
- STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY - HEALTH INSURANCE DEPARTMENT

MEDICAL EXAMINER'S REPORT - ADULT (PARAMEDICAL)
MEDICAL HISTORY portion of LIFE and/or HEALTH INSURANCE APPLICATION

File No.(s) _____

1. Name of Proposed Insured _____ Birth date _____

2. a. Name and Address of Personal Physician or Clinic (If none, so state.) _____

b. Date and Reason Last Seen and Treatment Given. (List medications prescribed, indicating those still being administered.) _____

<p>3. Have you, in the last 10 years, had or been treated for:</p> <p>a. Disorder of eyes, ears, nose, or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Dizziness, fainting, epilepsy, convulsions; frequent or severe headaches; paralysis or stroke; or mental or nervous disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Shortness of breath, allergy, asthma, emphysema, pneumonia or other respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Chest pain, high blood pressure, heart murmur, heart attack, or other disorder of the heart? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Ulcer, hernia, chronic diarrhea, or colitis; or disorder of the stomach, intestines, liver, or gallbladder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Varicose veins, hemorrhoids, or rectal disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Sugar, albumin, blood or pus in the urine; stones or other disorder of the kidneys, or bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Diabetes; thyroid or other endocrine disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Sexually transmitted disease; disorder of breasts or breast implants, prostate or reproductive organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Arthritis; injury or disorder of the spine, neck or back, arm, leg, shoulder, wrist, hand, hip, knee, ankle, or foot? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Deformity or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Disorder of skin or lymph glands, cyst, tumor, or cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m. Leukemia, anemia, immune deficiency or any other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>n. Recurrent fever, fatigue, or night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9. Have you, in the last 3 years, claimed or received any benefits because of injury, sickness, or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you used tobacco in any form in the last 12 months? (If yes, explain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has your father, mother, or any brother or sister ever had diabetes, cancer, kidney disease or mental illness? Have any had high blood pressure, stroke, or heart disease before age 60? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.)</p>
<p>4. Are you now receiving any treatment or taking prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>5. To the best of your knowledge and belief, are you now pregnant or ever had complications of pregnancy, including cesarean section? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6. Have you, in the last 5 years:</p> <p>a. Used cocaine, marijuana, hallucinogenic drugs, or narcotics not prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Been treated or counseled, or been advised to seek treatment or counsel, for alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>7. Have you had any unexplained change in weight in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>8. Other than above, have you, in the last 5 years:</p> <p>a. Had any mental or physical disorder not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Had or been advised to have treatment or a test in any medical facility such as a lab, clinic, emergency room, or hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Had or been told an electrocardiogram or x-ray was necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Had surgery or been told surgery was necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

I state that all information in this medical history is true and complete to the best of my knowledge and belief. This medical history will be part of my application.

Witness X _____
 Signature of Examiner or Paramedical Laboratory Technician

Dated On _____, _____, _____
 MONTH DAY YR

X _____
 SIGNATURE OF PROPOSED INSURED

PARAMEDICAL EXAMINATION

A. REGULAR PARAMEDICAL - TYPE I

<p>1a. Proposed Insured's Name</p> <p>b. Agent's Name</p> <p>c. Describe type of identification used to verify Proposed Insured's identity: <i>(Photo ID Preferable)</i></p> <p>d. For Life Insurance <input type="checkbox"/> Health Insurance <input type="checkbox"/></p> <p>e. Type and amount of insurance applied For:</p> <p>f. Are you related to Proposed Insured? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>g. How long have you known Proposed Insured?</p> <p>WHAT IS PROPOSED INSURED'S:</p> <p>2a. Height? (in shoes) ft. in. or cm.</p> <p>b. Weight? (clothed) lbs. or kgs.</p> <p>c. Weight change during past year? _____ lbs. gain <input type="checkbox"/> or _____ or kgs. loss <input type="checkbox"/> Cause:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">d. DID YOU MEASURE? Yes</td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>e. DID YOU WEIGH? Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>3. PULSE</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 25%;">Rate</td> <td style="width: 60%;">No. of Irregularities/Min.</td> </tr> <tr> <td>At Rest</td> <td></td> <td></td> </tr> </table> <p>4. BLOOD PRESSURE: Record resting blood pressure under "First Reading." If systolic is more than 138 or diastolic (disappearance of all sound) is more than 88, take two additional readings, at rest, 5 minutes apart. Report all observations.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 20%;">First Reading</td> <td style="width: 20%;">Second Reading</td> <td style="width: 45%;">Third Reading</td> </tr> <tr> <td>SYSTOLIC</td> <td></td> <td></td> <td></td> </tr> <tr> <td>DIASTOLIC</td> <td></td> <td></td> <td></td> </tr> </table>	d. DID YOU MEASURE? Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. DID YOU WEIGH? Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rate	No. of Irregularities/Min.	At Rest				First Reading	Second Reading	Third Reading	SYSTOLIC				DIASTOLIC				<p>5a. URINALYSIS</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Specific Gravity</td> <td style="width: 33%;">Albumin</td> <td style="width: 33%;">Sugar</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table> <p>b. Mail Specimen in container and envelope provided if:</p> <ol style="list-style-type: none"> (1) There are any abnormalities in specimen examined. (2) There is hypertension or a history of hypertension. (3) There is a history of diabetes mellitus, G.U. disease, or urinary abnormalities. (4) There is a family history of diabetes mellitus. (5) The initial blood pressure exceeds 150/90. (6) The age is over 55. (7) The AMOUNT APPLIED FOR is over \$200,000 of Life Insurance and/or \$1,000 per month or more of Disability Income Insurance. <p>c. Are you forwarding a specimen? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. Is Proposed Insured in menstrual cycle? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>6. Any obvious physical or mental impairment? Yes <input type="checkbox"/> No <input type="checkbox"/> (If "Yes," explain fully):</p> <p>7. Are any medications being taken? Yes <input type="checkbox"/> No <input type="checkbox"/> (If "Yes," list them.):</p>	Specific Gravity	Albumin	Sugar			
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B. AMPLIFIED PARAMEDICAL - TYPE II In addition to Part A, obtain blood samples and urine specimen for blood profile kit.

<p>8. BLOOD CHEMISTRIES DRAWN?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> (If "Yes" answer A)</p> <p>A. Is subject fasting?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> (If "No" answer B)</p>	<p>B. Time of last food intake (include soft drinks, coffee, tea, candy or gum)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">SPECIFY LIQUID:</td> <td style="width: 30%;">DATE/TIME BLOOD DRAWN:</td> </tr> <tr> <td style="height: 20px;"></td> <td style="text-align: right;">A.M. <input type="checkbox"/></td> </tr> <tr> <td style="height: 20px;"></td> <td style="text-align: right;">P.M. <input type="checkbox"/></td> </tr> <tr> <td>SPECIFY SNACK:</td> <td>DATE BLOOD PROFILE KIT MAILED: (INCLUDE URINE SPECIMEN)</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> <tr> <td>SPECIFY REGULAR MEAL:</td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> </table>	SPECIFY LIQUID:	DATE/TIME BLOOD DRAWN:		A.M. <input type="checkbox"/>		P.M. <input type="checkbox"/>	SPECIFY SNACK:	DATE BLOOD PROFILE KIT MAILED: (INCLUDE URINE SPECIMEN)			SPECIFY REGULAR MEAL:			
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SPECIFY REGULAR MEAL:															

C. FULL PARAMEDICAL - TYPE III In addition to Parts A and B, complete the following.

9. 12 LEAD ELECTROCARDIOGRAM - RESTING
(Please enclose tracing)

I certify that I have made this examination on _____ MONTH _____ DAY _____ YEAR at _____ A.M. P.M. AT:

my office	individual's home
individual's office	other

NAME AND ADDRESS OF LOCAL EXAMINING FACILITY

Please print, type or stamp your name, address and telephone number.

SIGNATURE OF EXAMINER _____