

**APPLICATION PART II  
MEDICAL HISTORY REPORT—LUC-123 2/02**

Symetra Life Insurance Company • Redmond, WA  
 American States Life Insurance Company • Indianapolis, IN

1. Full name _____ Date of Birth ____/____/____ DL # _____	4. Family History	Age if Living	Status of Health	Age at Death	Cause of Death
2. In the last 5 years have you used any form of tobacco or nicotine-based products? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Type _____ Quantity / Frequency _____ / _____ Mo/Yr	Father				
	Mother				
	Brothers & Sisters Number Living ____ Number Dead ____				
3. Name & Address of your personal physician. Name: _____ Address: _____ Date & reason last consulted: _____  What treatment was given or medication prescribed? _____	5. Has any family member listed above had cancer, diabetes, high blood pressure, heart disease, or kidney disease (past 7 years in Maryland)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, under <b>DETAILS</b> identify family member, disorder, age of onset. If there is a history of cancer, indicate type of cancer.				
	6. Have you had any physical disability or impairment in the past 10 years (7 years Maryland)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details.				

Give complete detail for all yes answers under **DETAILS**. Identify question number and include diagnosis, dates, duration, treatments and medications prescribed, and names/addresses of all physicians and hospitals. If more room is needed, please give additional information on a separate piece of paper.

7. Has Proposed Insured:	Yes	No	Details
a. Had any Life or disability insurance application declined or extra rated?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Within the past two years engaged in aviation activities as pilot or crew; scuba diving; parachuting; hang gliding; mountain/rock climbing; or racing of any motorized vehicles?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had any driver's license revoked or suspended, or been convicted of a felony crime?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Lost 10 or more pounds during the past 12 months? If "Yes", give amount and cause of weight loss and number of months at present weight in <b>DETAILS</b> .	<input type="checkbox"/>	<input type="checkbox"/>	
e. Received advice, counseling or treatment as the result of the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Used narcotics, amphetamines, cocaine, LSD, marijuana or hallucinogenic drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are you a U.S. citizen or permanent legal U.S. resident?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you have any plans to travel or live outside the U.S. or Canada?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Has proposed insured in the last 10 years (7 years in Maryland) had or been treated or diagnosed for any disorder or disease of:			
a. Respiratory system (lungs, bronchi, trachea, etc.) such as tuberculosis, asthma, emphysema, bronchitis or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Circulatory system (heart, blood, arteries, etc.) such as chest pain, high blood pressure, heart attack, or murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Digestive system (esophagus, stomach, intestines, pancreas, liver, etc.) such as ulcer, cirrhosis, hepatitis or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Nervous system (brain, nerves, etc.) such as paralysis, fainting, convulsions, stroke or mental or nervous disorders such as depression, anxiety or suicide attempt?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Genitourinary system (kidney, bladder, reproductive organs, etc.) such as infection, bleeding, male or female disorders, or sexually transmitted diseases (not including HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Musculoskeletal system (muscles, spine, bones, joints, etc.) such as arthritis, back or joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Eyes, ears, or skin?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Either a benign or malignant growth, cancer, tumor, or mass?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Diabetes, hypoglycemia or impaired glucose tolerance?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Glandular disease or disorder (thyroid, adrenal, lymph glands, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Within the past 5 years has the proposed insured been treated or diagnosed for:			
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV) antibodies?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Or had any other impairment, sickness or diagnostic procedures such as X-ray, EKG, laboratory tests?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Or been hospitalized or had surgery performed, advised or contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Or consulted, been examined or treated by any physician, psychiatrist, or medical practitioner not named above or for any cause not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Are you receiving treatment or taking medication of any kind prescribed by a licensed medical physician or medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Are you taking medications, supplements, or herbs of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	

All statements and answers to the above questions in this Part II Application are, to the best of my knowledge and belief, true, complete and correctly stated. I agree that a copy of this Part II Application shall be attached to and form part of my pending application for insurance, and also of any subsequent application by me for insurance with this Company, unless I then undergo another medical examination which by its terms is made a part of such application and of subsequent applications.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Witness \_\_\_\_\_  
Witness/Agent

Signature of Proposed Insured \_\_\_\_\_

**MEDICAL EXAMINER'S REPORT (not part of the application)**

1. a.	<b>Height (In Shoes)</b>	<b>Weight (Clothed)</b>	<b>Chest (Full Inspiration)</b>	<b>Chest (Forced Expiration)</b>	<b>Abdomen, at Umbilicus</b>
	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

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

	1	2	3
Systolic			
Diastolic 5th phase			
3. Pulse:	<b>At Rest</b>	<b>After Exercise</b>	<b>3 Minutes Later</b>
Rate:			
Irregularities per min.			

4. 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)*

Location	Murmur(s)	
	M No. 1	M No. 2
Constant	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>
Systolic	<input type="checkbox"/>	<input type="checkbox"/>
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>

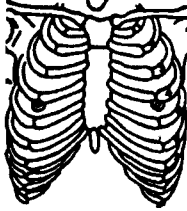
Carefully locate apex by **X**

Indicate entire area within which murmur is heard by

Indicate point of greatest intensity by

Indicate direction of transmission by

Describe all murmurs or abnormal heart sounds.  
 Include intensity, location, area of transmission and pertinent effects of exercise and body position. We want your diagnosis!



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

5. Is there, on examination, any abnormality of the following:  
*(Circle applicable items and give details.)*
- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| (a) Eyes, ears, nose, mouth, pharynx? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(If vision or hearing markedly impaired, indicate degree and correction.)</i>    |                          |                          |
| (b) Skin (include scars); lymph nodes; varicose veins? .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Nervous system (include reflexes, gait, paralysis)? .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Respiratory system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Abdomen (include scars)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Endocrine system (include thyroid and breasts)? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Retinopathy (indicate K-W)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Peripheral pulses? (decreased bruits)? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
6. Are there any hernias? .....
7. Are you aware of anything about the health habits, environment or mode of life of proposed insured which might be unfavorable? (If "yes," give details) .....
8. Are you unrelated to both proposed insured and agent? .....

**Dip Stick Urinalysis**

Sugar?	Albumin?
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Have you mailed blood and urine samples to our lab?  Yes  No

Name of Agent \_\_\_\_\_

I certify that I have carefully examined \_\_\_\_\_, whose signature is affixed to the foregoing declarations this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_ o'clock  A.M.  P.M.

Examined at \_\_\_\_\_  
 (Town) (County) (State)

\_\_\_\_\_  
 (Medical Examiner)

\_\_\_\_\_  
 (P.O. Address of Medical Examiner)

- Symetra Life Insurance Company • P.O. Box 34690 • Seattle, WA 98124-1690
- American States Life Insurance Company • Indianapolis, IN

**NOTICE AND CONSENT FOR AIDS-RELATED BLOOD, URINE, OR SALIVA TESTING**

To evaluate your insurability, the Insurer named above, Symetra, has requested that you provide a 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 and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure. Please see additional information regarding testing on the reverse side of this form.

**TESTS TO BE PERFORMED**

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

**NOTIFICATION OF TEST RESULTS**

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

\_\_\_\_\_ Name

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP

If you do not wish to know the results of the test, initial here: \_\_\_\_\_. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: \_\_\_\_\_. The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

The result will be sent to that person by registered mail with restricted delivery.

**CONSENT**

I have read and I understand this Notice and Consent for AIDS-Related Blood, Urine, or Saliva Testing. I voluntarily consent to providing a sample of my blood, urine, or saliva (or providing a sample of my child's blood, urine, or saliva) and to the testing of that blood, urine, or saliva and the disclosure of the test results as described above. I have read the information on the reverse side of this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP

\_\_\_\_\_ Signature of Proposed Insured or Parent/Guardian \_\_\_\_\_ Date Signed

**HIV TEST COUNSELING RESOURCES LIST**

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Symetra Life Insurance Company. Therefore, Symetra makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Symetra makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. If you need further information, we suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross.

**AIDS HOTLINE — U.S. PUBLIC HEALTH SERVICE**  
(800) 342-AIDS

**SPANISH AIDS HOTLINE**  
(800) 344-7432

**TTY INFORMATION**  
Information and Referral for Hearing Impaired  
(213) 464-0029

**KERN COUNTY AIDS TEAM — Bakersfield**  
(805) 861-3631

**CENTRAL VALLEY AIDS TEAM — Fresno**  
(209) 264-2436

**AIDS PROJECT — EAST BAY — Oakland**  
(415) 420-8181

**SACRAMENTO AIDS FOUNDATION**  
Sacramento  
(916) 448-2437

**SAN FRANCISCO AIDS FOUNDATION**  
San Francisco  
(415) 846-5855

**AIDS PROJECT — LOS ANGELES**  
West Hollywood  
(213) 876-8951

**INLAND AIDS PROJECT**  
Riverside/San Bernardino Counties  
(714) 784-2437

**SANTA CLARA COUNTY ARIS PROJECT**  
Campbell  
(408) 370-3272

**SONOMA COUNTY AIDS INFORMATION HOTLINE**  
(707) 579-AIDS

**AIDS HOTLINE — SOUTHERN CALIFORNIA**  
(800) 922-AIDS

**HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA**  
Social Services — Southern California  
Hemophilia AIDS Information  
(818) 792-6192  
(714) 740-2222

**CALIFORNIA DEPT. OF HEALTH SERVICES**  
Statewide Services —  
Office of AIDS — Sacramento  
(916) 323-7415

**AIDS SERVICES FOUNDATION OF ORANGE COUNTY — Costa Mesa**  
(714) 646-0411

**SAN DIEGO AIDS PROJECT**  
(619) 543-0300 — City of San Diego  
(619) 945-6000 — City of Vista

**SANTA BARBARA COUNTY AIDS HOTLINE**  
(805) 965-2925

**SHASTA COUNTY HELPLINE**  
(916) 225-5252

### **PRE-TESTING CONSIDERATIONS**

Many public health organizations have recommended that before taking an AIDS-related blood, urine, or saliva test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

### **MEANING OF POSITIVE TEST RESULTS**

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will 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.

### **CONFIDENTIALITY OF TEST RESULTS**

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Informations Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.