

## PART 2, STATEMENT TO MEDICAL EXAMINER

Continuing Application to Southern Farm Bureau Life Insurance Company, Jackson, Miss.

Social Security No. _____					Policy/Application No. _____						
1. Full Name (Print) _____					2. Male or Female M <input type="checkbox"/> F <input type="checkbox"/>		3. Birthdate Mo. Day Yr. _____			4. Age _____	
5. Address		Street or R.F.D. No.		City	State	Zip Code					

Answer each of the following questions "Yes" or "No". For each question answered "Yes", give complete details in space provided. **ANSWER EVERY QUESTION.**

To the best of your knowledge and belief, have (are) you:

	Yes	No	
6. ever			Give complete details for every "Yes" answer to the questions 6-14. Include question number, details, dates, name and address of attending physicians, and hospitals:
(a) been declined, postponed, rated, or charged an extra premium for life or health insurance? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) received or claimed benefits for any injury or sickness? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) been rejected or deferred from military service or been given a medical discharge? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(d) had, or been told that you had an immune deficiency disorder, AIDS, the AIDS Related Complex (ARC), or test results indicating exposure to the AIDS virus? .....	<input type="checkbox"/>	<input type="checkbox"/>	
7. in the past 10 years			
(a) been in, or advised to go to, a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) had x-ray, electrocardiogram, blood study, or other diagnostic test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) attempted suicide? .....	<input type="checkbox"/>	<input type="checkbox"/>	
8. in the past 10 years had, or been told that you had			
(a) dizziness, fainting spells, epilepsy, mental illness, severe headaches, or any disease or disorder of the brain or nervous system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) asthma, emphysema, hay fever, chronic cough, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or circulatory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(d) any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(e) nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breasts, uterus, ovaries, or complications of pregnancy? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(f) gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(g) rheumatic fever, diabetes, or sugar, albumin, or blood in the urine? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(h) cancer, or tumor or ulcer of any kind, or venereal disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(i) varicose veins, varicose ulcers or phlebitis, or a hernia of any kind? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(j) any disease or disorder of the eyes, ears nose or throat? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(k) anemia, goiter, or any disease or disorder of the blood or lymph glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
9. in the past 5 years			
(a) consulted or been treated or examined by any physician or practitioner not named above or for any other causes? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) had regular physical examinations? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) used alcoholic beverages to excess or intoxication of barbiturates, sedatives, or tranquilizers habitually, or been arrested for driving while intoxicated? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(d) used heroin, morphine, cocaine, L.S.D., marijuana, or any amphetamine, or other narcotic or addictive drug? .....	<input type="checkbox"/>	<input type="checkbox"/>	
10. in the past 2 years gained or lost more than 10 pounds of weight? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(if "Yes," state which and give the reason)			
11. now			
(a) afflicted with any abnormality, deformity, disease, or disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(b) receiving treatment or taking medication of any kind? .....	<input type="checkbox"/>	<input type="checkbox"/>	
(c) pregnant (if "Yes", indicate month of pregnancy) .....	<input type="checkbox"/>	<input type="checkbox"/>	
(d) engaged in a regular program of exercise .....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have any of your parents, brothers, or sisters ever had heart disease, cancer, diabetes, mental illness, or attempted or committed suicide? (If yes, give details) .....	<input type="checkbox"/>	<input type="checkbox"/>	
13. During the last 2 years have you missed work or school because of any illness or injury? If "yes", the number of days and reasons .....	<input type="checkbox"/>	<input type="checkbox"/>	
14. Smoked cigarettes or used tobacco in any form in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>	

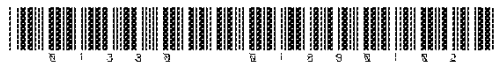
I hereby represent that my answers to the foregoing questions are complete and true to the best of my knowledge and belief and I expressly agree that this Part 2 shall form a part of my application for life insurance.

I hereby authorize any licensed physician, medical practitioner, hospital, veterans hospital, clinic or other medical or medically related facility that has any records or knowledge of me or my health to give Southern Farm Bureau Life Insurance Company, or its reinsurers, any such information.

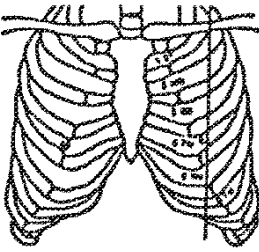
Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Yr. \_\_\_\_\_

Witness to Signature \_\_\_\_\_ M.D. \_\_\_\_\_ Proposed Insured \_\_\_\_\_

(Signature in Full)



## PART 3, REPORT OF MEDICAL EXAMINER

1. How long have you known Proposed Insured? 2. Are you related to the Proposed Insured or the agent? 3. In your opinion, is the Proposed Insured a good insurance risk? If not, please comment in No. 19. 4. a. Height _____ ft. _____ in. b. Weight without coat _____ lbs. c. Chest: Forced expiration _____ in. Forced inspiration _____ in. d. Circumference of abdomen _____ in. e. Did you: Weigh Proposed Insured? Measure Proposed Insured? 5. Blood Pressure: Systolic _____ Diastolic { At 4th phase _____ At disappearance of sound _____ 6. Pulse: Rate seated. (If intermittent or irregular complete heart chart.) 7. Heart: (If any abnormality complete heart chart) { Any murmurs? Any enlargement?	9. a. Are eye grounds abnormal? b. Is vision abnormal? 10. Any hearing or ear disorder? 11. Any pathology of skin, breasts, Lymph nodes or throat? 12. Any deformity or defect? 13. Any goiter? If yes, state size and kind. 14. Lungs: Is there any evidence of past or present disease? Give details. 15. Abdomen: a. Any scars? b. Any tenderness or masses? c. Any Hernia? Character and extent? d. Any enlargement of liver or spleen? 16. Has the applicant ever had syphilis or other venereal disease? 17. Brain or nervous system: a. Are the pupils unequal? b. Are the pupils fixed? c. Are knee jerks abnormal?																													
8. <b>COMPLETE HEART CHART...IF:</b> a. Any abnormality of the heart is found. b. Systolic blood pressure is over 140 or under 100. c. Diastolic blood pressure is over 90. d. Pulse pressure is over 60 or under 30. e. Pulse is irregular, or rate is over 90 or under 60. f. There is history of rheumatic fever. g. Heart has ever been criticised. h. There are symptoms of toxic goiter.		18. Mail specimen of urine to lab when: a. Amount of application is over \$100,000. b. Proposed Insured is age 55 or older. c. There is history of elevated blood pressure. d. There is history of albumin or sugar.  ALL OTHER URINE REQUESTS WILL BE MADE FROM THE HOME OFFICE <input type="checkbox"/> Please check if specimen was mailed to lab.																												
Exercise Test: Require the Proposed Insured to take fifty vigorous hops, 10 bending exercises, or enough exercise to raise the pulse rate to 100 or more		19. Comments or details regarding health, habits or character.																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 15%;">Before Exercise</th> <th style="width: 15%;">Immediately After Exercise</th> <th style="width: 10%;">Three Min. Later</th> </tr> </thead> <tbody> <tr> <td rowspan="2">a. Pulse</td> <td>Rate</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Number of irregularities per minute</td> <td></td> <td></td> <td></td> </tr> <tr> <td rowspan="2">b. Blood Pressure</td> <td>Systolic</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diastolic (5th Phase)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Murmur</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Before Exercise	Immediately After Exercise	Three Min. Later	a. Pulse	Rate				Number of irregularities per minute				b. Blood Pressure	Systolic				Diastolic (5th Phase)				c. Murmur					
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d. Are there any evidences of failing compensation such as Dyspnea, Cyanosis or Edema? e. Is the point of maximal impulse abnormal in location? f. Hypertrophy present? _____ Slight _____ Moderate _____ Marked _____ g. Murmur is: <input type="checkbox"/> Constant <input type="checkbox"/> Transmitted <input type="checkbox"/> Systolic <input type="checkbox"/> Apical <input type="checkbox"/> Soft (Gr. 1-2) <input type="checkbox"/> Inconstant <input type="checkbox"/> Localized <input type="checkbox"/> Presystolic <input type="checkbox"/> Aortic <input type="checkbox"/> Mod. (Gr. 3-4) <input type="checkbox"/> Diastolic <input type="checkbox"/> Other <input type="checkbox"/> Loud (Gr. 5-6) After exercise: <input type="checkbox"/> Unchanged <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Absent																														
Does murmur impress you as organic? _____ As functional? _____																														
Show Location of: Apex by _____ X Area of murmur by _____ <input type="checkbox"/> Point of greatest intensity by _____ O Transmission by _____ →																														
Diagnosis? Your Impression?		20. Examination was made: At Proposed Insured's place of business <input type="checkbox"/> at _____ A.M. At Proposed Insured's residence <input type="checkbox"/> At Examiner's office <input type="checkbox"/> _____ P.M.  on _____ Month    _____ Day    _____ Year  _____ M.D. Signature of Medical Examiner  _____ Address of Medical Examiner  _____ Print Name If Signature Illegible  STATE YOUR FEE HERE \$ _____																												

PLEASE PRINT THE NAME OF AGENT REQUESTING EXAM: \_\_\_\_\_

AGENT'S CODE: \_\_\_\_\_

