



Details (Continued):

i)	Anemia; leukemia; or any other disorder of the blood or lymph glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j)	Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k)	Any disease or disorder of the eyes, ears, nose, or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you now, or within the last six months, under observation or taking medication or treatment? (Including over the counter medications, vitamins, herbal supplements, etc.)	<input type="checkbox"/> Yes* <input type="checkbox"/> No
7.	Do you have any doctor's visits, medical care, or surgery scheduled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Other than the above, during the past five years have you had any:	
a)	Checkup; electrocardiogram; chest x-ray; or medical test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you:	
a)	ever been diagnosed or treated by a member of the medical profession as having Acquired Immuna Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	ever tested positive during a medical examination for life insurance for the AIDS (HIV) virus or for antibodies to the AIDS (HIV) virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b)	Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Do you exercise?  Yes  No Type \_\_\_\_\_ How often? \_\_\_\_\_

12. Are you now pregnant?  Yes  No If "Yes", estimated date of delivery? \_\_\_\_\_

13. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, indicate below.)  Yes  No

Relationship to Proposed Insured:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

14. a) Do you currently use any mechanical equipment such as a walker, wheelchair, long leg braces or crutches?  Yes  No  
b) Do you need any assistance or supervision with the following activities: bathing, dressing, walking, moving in/out of a chair or bed, toileting, continence or taking medication?  Yes  No

I have read the answers to questions 2-14 before signing. They have been correctly written, as given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Witness to Signature	City and State	Mo./Day/Year	Signature of Proposed Insured (Parent or Guardian if under 18)



**Report of Paramedical/Medical Examiner**

- Complete Sections I and III for Paramedical Exam
- Complete Sections I, II and III for Physician's Exam

**Section I**

1. (a) Date of birth \_\_\_\_\_ (b) Sex: M  F  (c) If female, was proposed insured menstruating on date of this examination? Yes  No

Height (in shoes)		Weight (clothed)	Chest (full inspiration)	Chest (forced expiration)	Abdomen (at umbilicus)
ft	in.	lbs.	Males in.	Males in.	Males in.

Did you measure? Yes  No  Did you weigh? Yes  No

3. Blood Pressure (Record ALL readings - at least two):

Sitting Systolic/Diastolic - 5th phase /	If systolic over 140 or diastolic over 90, repeat later in exam /
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4. Pulse At Rest: Rate (per min.) \_\_\_\_\_ Irregularities (per min.) \_\_\_\_\_

5. Is appearance unhealthy or older than stated age? Yes  No

6. Urinalysis: Protein: Positive  Negative  Sugar: Positive  Negative   
Is blood also being sent to lab? Yes  No  ECG done?: Yes  No

Urine samples must be sent to lab for analysis  
**Place Kit Sticker Here**

**Section II**

7. Heart: Is there any:

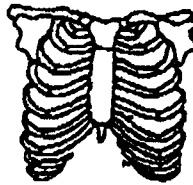
- a) Enlargement? Yes  No
- b) Murmur(s)? Yes  No   
(If Yes, complete below)
- c) Dyspnea? Yes  No
- d) Edema? Yes  No

Murmur 1      Murmur 2

- Location (Apical, Aortic, Pulmonic, Parasternal)
- Timing (Systolic, Presystolic, Diastolic)
- Quality (Coarse, Blowing, Rumbling, Musical)
- Loudness (Grade 1-6)
- Constant (Yes or No)
- Transmitted (Yes or No)
- After Exercise (Increased, Absent, Unchanged, Decreased)


Indicate:

- Apex by:  X
- Murmur area by:  □
- Point of greatest intensity by:  O
- Transmission by:  →



Details for answers to questions 7-11.

8. Is there on examination any abnormality of the following?
- a) Eyes, ears, nose, mouth pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)  Yes  No
  - b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?  Yes  No
  - c) Nervous system (include reflexes, gait, and paralysis)?  Yes  No
  - d) Respiratory system?  Yes  No
  - e) Abdomen (describe scars, liver enlargement)?  Yes  No
  - f) Genitourinary system?  Yes  No
  - g) Endocrine system (include thyroid)?  Yes  No
  - h) Musculoskeletal system (include spine, joints, amputations, and deformities)?  Yes  No
9. Are there any hernias?  Yes  No
10. Are you aware of additional medical history?  Yes  No
11. Are you the personal physician of the applicant?  Yes  No
12. Please provide your overall clinical impression of proposed insured:  Yes  No

**Section III Name of person examined**

Place of exam:  Examiner's office     Proposed Insured's Residence     Proposed Insured's Business

City/State \_\_\_\_\_ Date/Time of exam \_\_\_\_\_  
 Agent/Broker \_\_\_\_\_ Branch/District # or Agency Name \_\_\_\_\_  
 Signature of Paramedical/Medical Examiner \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Printed Name \_\_\_\_\_ Address \_\_\_\_\_



Metropolitan Life Insurance Company  
One Madison Avenue  
New York, NY 10010-3690

Security First Life Insurance Company  
1300 Delaware Trust Bldg, P.O. Box 25130  
Wilmington, DE 19899

The Company checked off above is referred to as "the Insurer."

**CALIFORNIA NOTICE AND CONSENT FORM FOR BLOOD OR OTHER BODILY  
FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the insurer named above ("the Insurer") has requested that you provide a sample of your blood or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver kidney disorders, diabetes, and immune disorders.

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 in the underwriting and claims review process. If the HIV test is positive the results will be reported to the Medical Information Bureau (MIB, Inc.), in a generic code which signifies only non-specific blood or other bodily fluid test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in more specific manner. 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this HIV Notice and Consent form. I have also received a list of AIDS counseling centers from the Insurer. I voluntarily consent to the withdrawal of blood or other bodily fluids from me, the testing of that blood or other bodily fluids, and the disclosure of the test results as described above.

In the event of an HIV test result that is other than normal, I authorize the Insurer to send the test results to the following health care professional for post-test counseling.

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
City State ZIP Code

**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.**

\_\_\_\_\_  
Proposed Insured (Print) Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian Date State of Residence

\_\_\_\_\_  
Agency / District Name/Number