

**Answers Made
to Medical
Examiner**

**AMERICAN UNITED LIFE
INSURANCE COMPANY***
a ONEAMERICA® financial partner
One American Square
P.O. Box 368
Indianapolis, IN 46206-0368

PIONEER MUTUAL LIFE INSURANCE CO.
*A stock subsidiary of American United
Mutual Insurance Holding Company*
a ONEAMERICA® financial partner
101 North 10th Street, P.O. Box 2546
Fargo, ND 58108

**THE STATE LIFE
INSURANCE COMPANY**
*a ONEAMERICA®
financial partner*
P.O. Box 406
Indianapolis, IN 46206



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

Full Name of Proposed Insured _____ Date of Birth _____ (SSN) _____

Name and Address of Personal Physician (If none, so state.) _____

 Date, reason and results for last doctor visit or consultation. _____

1. Is any person proposed for insurance now under observation, receiving treatment or taking medication prescribed by a member of the medical profession? Yes No

2. In the past 10 years (7 years in MD), has any person proposed for insurance ever been diagnosed as having, been treated for or ever had:

a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels? Yes No

b. Cancer, tumors, Kaposi 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? Yes No

c. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, nervous or mental disorder including anxiety, depression or attempted suicide? Yes 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? Yes 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? Yes No

f. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of stomach, intestine, gallbladder or spleen? Yes No

g. Hepatitis, cirrhosis or disorder of the liver or pancreas? Yes No

h. Anemia, bleeding tendency or other disorder of the blood? Yes No

i. Disorder of eyes, ears, nose or throat? Yes No

j. Deformity, lameness or amputation? Yes No

k. Are you pregnant? If yes, due date _____ Yes No

3. Has any person proposed for insurance within the past 5 years:

a. Had a checkup, consultation, illness, injury or surgery? Yes No

b. Had any diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study? Yes No

c. Been a patient in a hospital, clinic, sanitarium, or other medical facility? Yes 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? Yes No

e. Had any condition resulting in over 10 consecutive days of time lost from work? Yes No

f. Requested or received a pension, benefits or payment because of injury, sickness or disability? Yes No

Details of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS. (Include all dates, diagnoses, names and addresses of all attending physicians and medical facilities.)
 (Enter additional details on page 2.)

Details of "Yes" answers continued:

4. Family History

	Age if still Living	Age at Death	State of Health/ Cause of Death	Cancer (all types)	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

5. Nicotine Use:

a. Never Present Former

b. Type of nicotine or tobacco used: _____

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

6. Answer for the applicable state where the form is signed:

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

Has any person proposed for insurance been diagnosed or treated by a member of the medical profession as having AIDS? Yes No

Wisconsin:

Has any person proposed for insurance ever been diagnosed or treated for AIDS by a member of the medical profession, or had a positive test result confirming presence of the AIDS virus (HIV, HTLV-III)? (Test limited to FDA licensed blood tests for AIDS. Test performed at anonymous counseling and testing sites are confidential and should not be reported) Yes No

Answer if state not listed above:

Has any person proposed for insurance 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 to 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 and 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

Witness _____
Signature of Medical Examiner Signature of Proposed Insured



INSURANCE COMPANY

NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

THE HIV ANTIBODY TEST

To evaluate your insurability, the Insurer named above has requested that you provide a specimen 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. A series of tests will be performed by a licensed laboratory through medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, it is not 100% accurate. 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 infection occurred within the previous 3-6 months prior to the test.

MEANING OF TEST RESULTS

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

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. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

COUNSELING

Many public health organizations have recommended that before taking an AIDS-related test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling at your own expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have any questions or concerns, you may wish to consult your own physician or health care provider. A list of counseling resources is provided for your information.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.

Name of Physician: _____ Address _____

CONFIDENTIALITY OF TEST RESULTS

All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. No other disclosure will be made of the results except as required by law.

CONSENT

I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and disclosure of the test results as described above.

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 (Please Print)

Date

Signature of Proposed Insured

Date