



Transamerica Life Insurance Company
 Home Office: 4333 Edgewood Road NE
 Cedar Rapids, IA 52499

GA # _____
Application Part 2
Health History
 Paramedical Medical
 File # _____

1. Proposed Insured: <i>(Print Full Name)</i>	2. Date of Birth: Month Day Year	3. Social Security #
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4. **Name/Address/Phone of primary care physician:**

Name: _____ Address: _____

Phone: (_____) _____ City/St/Zip: _____

Date and reason for last visit: _____

Give complete details of all yes answers to questions 5 - 8, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

5. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**

	Yes	No
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	<input type="checkbox"/>	<input type="checkbox"/>
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	<input type="checkbox"/>	<input type="checkbox"/>
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, tumor, polyp or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
j. Any physical deformity or amputation?	<input type="checkbox"/>	<input type="checkbox"/>
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	<input type="checkbox"/>	<input type="checkbox"/>

Details: _____

6. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**

	Yes	No
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	<input type="checkbox"/>	<input type="checkbox"/>

7. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**

	Yes	No
a. Consulted, been examined or been treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had observation or treatment at a clinic, hospital or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have a surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	<input type="checkbox"/>	<input type="checkbox"/>
f. Had any injury requiring treatment?	<input type="checkbox"/>	<input type="checkbox"/>



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|--|--------------------------|--------------------------|
| 8. | Yes | No |
| a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has your weight changed by more than 15 pounds in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

9. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** Yes No *If yes, list all and indicate why.*

10. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters #				

11. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** Yes No *If yes, indicate type, frequency and date last used.*

12. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** Yes No *If no, provide complete details.*

13. Do you participate in regular weekly exercise?..... Yes No
14. Do you participate in athletics (*Team or Individual*)?..... Yes No
15. Have you ever used any tobacco products?
16. Do you get regular examinations by your health care provider?
17. Do you get regular annual dental checkups?
18. Do you clean your house or do yard work?.....
19. Do you have a pet?
20. Are you a member of a social group or volunteer for charity work?.....

It is represented that the statements and answers given above are representations and not warranties. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on _____, _____

Signature of Vendor Representative
or Physician

Signature of Proposed Insured

To The Examiner:

File # _____

(Not a Part of the Application for Insurance)

If completed in person, the questions on Pages 1 and 2 must be completed and signed before you.

You must ask the Proposed Insured each question and record the answer.

Questions 21 & 22 For Medical Examiner Use only

Name of Proposed Insured: _____

Social Security #: _____

Height: _____ Ft. In. Did you measure? _____

Weight: _____ Lbs. Did you weigh? _____

Males Only

A. Chest Expanded _____ In.

B. Chest Contracted _____ In.

C. Abdomen _____ In.

Blood Pressure Obtain 3 Readings

Systolic _____ mm Diastolic _____ mm

Systolic _____ mm Diastolic _____ mm

Systolic _____ mm Diastolic _____ mm

Pulse Rate _____ per minute.

Irregularities Yes No Give number per minute _____

Yes No

Are you in any way related to the Proposed Insured or Insurance Producer? *If yes, give details.*

Yes No

Was the examination conducted in a language other than English? *If yes, indicate language used and, if applicable, name & relationship of person acting as interpreter.*

Name of Insurance Producer requesting examination: _____

INSTRUCTIONS Complete all questions above.

No examiner has any authority to issue a certificate of health or to declare the Proposed Insured acceptable for insurance. Under our rules, only the Company's underwriting department has authority to determine the insurability of the applicants for insurance.

Mail the specimen for laboratory analysis to the laboratory listed on the collection kit or as instructed by your paramedical company.

EXAMINATION WAS MADE AT:

- My Office
- Residence of Proposed Insured
- Place of Business of Proposed Insured.
- Other: _____

At _____ AM/PM on _____, _____

Others present (*indicate None or list name/relationship*): _____

21. ANY EVIDENCE OF PAST OR PRESENT MEDICAL CONDITION OR DISORDER OF THE:

Yes No

- a. Brain, nervous system?
- b. Ears, nose, eyes, throat, teeth or gums?
- c. Thyroid or lymph glands?
- d. Heart, blood vessels? (*If yes, complete Question No. 22.*)
- e. Lungs?
- f. Stomach or abdominal organs?
- g. Genito-urinary system?
- h. Skin or extremities?

22. TO BE COMPLETED IF QUESTION 21d IS ANSWERED YES.

Yes No

- a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?
- b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?
- c. Are there gallops (S3 or S4)?
- d. Are there ejection sound(s) or systolic click(s)?
- e. Is/Are there murmur(s) present?

If yes, fully describe under "Details". For murmurs, include timing (systolic or diastolic), intensity (grd. 1-6), location, transmission, radiation.

Details: _____

SIGNATURE OF EXAMINER _____

Print Examiner Name: _____

Company Branch #: _____

Tax Identification Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____

If mailing, send to: Transamerica Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, IA 52499
AWD Fax #: 1-800-814-2205

- Life Investors Insurance Company of America
- Monumental Life Insurance Company
- Stonebridge Life Insurance Company
- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

Notice and Consent for HIV-Related Testing OREGON
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AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have engaged in high risk behaviors with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

HIV Antibody Test

Before you consent to testing, please read the following important information:

Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

Positive Test Results. If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.

Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

False positives: the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Re-testing should be done to help confirm the validity of a positive test.

False negatives: the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Possible Adverse Effects of Test. A positive test result may cause you significant anxiety. A positive test result may result in uninsurability for life, health, or disability insurance policies for which you may apply. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Disclosure of Results. A positive test result will be disclosed to you or the physician or county health department that you designate.

Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. When necessary for business reasons in connection with insurance you have or have applied for, an insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purpose for which that disclosure is authorized. In addition, a report of a non-specific test abnormality may be made to the Medical Information Bureau, a national insurance data bank.

Prevention. Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Information. Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotlines at (800) 777-2436 or (503) 223-2437.

**Notice and Consent for
HIV-Related Testing
OREGON**

Authorization and Consent for AIDS-Related Testing

To evaluate your insurability, it has been requested that you provide a blood, oral or urine specimen for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. The HIV test protocol consists of two ELISA tests confirmed by a Western Blot or another test or series of tests that the state epidemiologist finds to be no less accurate. An HIV test will be considered other than normal only after confirmation by a laboratory procedure that the state health officer has determined to be extremely reliable. If your HIV test results are other than normal, your application will be adversely affected. If your HIV test results are normal, no routine notification will be sent to you.

If the HIV test results are other than normal, you may designate one or more of the following to receive the test results:

A Physician

The County Health Department

Name

Name

Phone Number

Phone Number

Street

Street

City, State, Zip Code

City, State, Zip Code

Directly to me (If you request the results be sent directly to you, you will be contacted by the Company to reconsider naming a personal physician to receive the results.)

I have read and understand this *Notice and Consent for HIV-Related Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing*, and I consent to the testing of my blood, urine or oral specimen for HIV antibodies and disclosure of the test results as described. This consent is valid for six months following the date this form is signed.

Proposed Insured (Please Print)

Date of Birth

Signature of Proposed Insured

Date Signed