

# PART TWO LIFE INSURANCE APPLICATION

## GENERAL INSTRUCTIONS TO THE MEDICAL EXAMINER

THE EXAMINATION MUST BE MADE IN PRIVATE: AGENT MUST NOT BE PRESENT

- All questions are to be completed by the medical examiner.
- The "Part Two" below becomes a part of the contract of insurance and, therefore, completion of all sections and the signature of the Proposed Insured with signature of witness is necessary.

REQUESTER'S NAME (*print full name*) \_\_\_\_\_

REQUESTER'S PHONE NUMBER \_\_\_\_\_

## POLICY RISK INFORMATION - MEDICAL HISTORY

PROPOSED INSURED (*Print name in full*) \_\_\_\_\_ Date of Birth (*Mo./Day/Yr.*) \_\_\_\_\_ Birthplace \_\_\_\_\_ Social Security No. \_\_\_\_\_

Name and address of personal physician (If none so state) \_\_\_\_\_

Date and reason last consulted \_\_\_\_\_

What diagnosis was made? What treatment was given or medication prescribed? Are any follow-up tests planned? \_\_\_\_\_

- |                                                                                                                                                                                                                       | YES                      | NO                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Has the Proposed Insured ever had any indication of, been treated for or received medical consultation for:                                                                                                        |                          |                          |
| a. Disorder of eyes, ears, nose or throat? .....                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Seizures, convulsions, stroke, paralysis, fainting, dizziness, frequent headaches, or disorder of the brain, nerves or nervous system? .....                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Nervous or emotional disorder, depression, anxiety or attempted suicide? .....                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart disease, chest pain, heart attack, heart murmur, high blood pressure, rheumatic fever, palpitation, irregular heart beat, peripheral vascular disease or other disorder of the heart or blood vessels? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma, pneumonia, emphysema, infection, shortness of breath, persistent hoarseness or cough, bloodspitting, bronchitis, pleurisy, tuberculosis or other disorder of respiratory system? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Jaundice, intestinal bleeding, colitis, diverticulitis, pancreatitis, hepatitis, ulcer or other disorder of esophagus, stomach, duodenum, intestines, rectum, gallbladder, liver, spleen or pancreas? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Disorder of the kidneys, bladder, prostate, breasts, reproductive organs or sexually transmitted disease or history of protein, sugar, blood or pus in urine? ..                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Diabetes, thyroid, elevated cholesterol or other endocrine disorders? .....                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any disease or disorder of back, neck, spine, bones, ligaments, muscles, tendons or joints, arthritis, neuritis, rheumatism, gout, disc disorders, deformity or amputation? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Cancer, tumors, cysts, abnormality of skin or disorder of lymph glands? .....                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies, anemia or other disorder of the blood? .....                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Had any weight changes in the past year? .....                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |

*For "YES" responses: identify question # and circle applicable items. Include diagnoses, treatments, dates, duration of illness or injury, if recovery was full and complete, and names/addresses of all attending physicians/medical facilities.*

The Travelers Insurance Company  
P.O. Box 990018 Hartford, CT 06199-0018

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P.O. Box 990018 Hartford, CT 06199-0018



## POLICY RISK INFORMATION - MEDICAL HISTORY (CON'T)

PROPOSED INSURED (*Print name in full*): \_\_\_\_\_

- |                                                                                                                                                                                                                                                                |                          |                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| <p>2. Has the Proposed Insured ever been diagnosed or received treatment for an immune disorder or Acquired Immune Deficiency Syndrome (AIDS) or, for the purpose of obtaining insurance, had a positive test for infection by the AIDS (HIV) virus? .....</p> | <b>YES</b>               | <b>NO</b>                |  |
|                                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |  |
3. Other than the above, has the Proposed Insured:
- |                                                                                                                                           |                          |                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| a. Ever had any mental or physical disorder or illness, injury, surgery, or been a patient in a hospital or other medical facility? ..... | <input type="checkbox"/> | <input type="checkbox"/> |  |
| b. Within the past 5 years, had any physical exam, consultation, EKG, x-ray or other medical test? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| c. Been advised to seek medical attention, have surgery or have other medical tests done which have not been performed? .....             | <input type="checkbox"/> | <input type="checkbox"/> |  |
4. Has the Proposed Insured:
- |                                                                                                                                                                     |                          |                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| a. Ever used cocaine, marijuana, heroin or any other illicit drug or been advised to restrict the use of alcohol or any other drug? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |  |
| b. Ever received medical treatment, been counseled for or joined an organization which has as its purpose the curing or controlling of alcohol or drug abuse? ..... | <input type="checkbox"/> | <input type="checkbox"/> |  |
5. Has the Proposed Insured during the past year:
- |                                                                                                                     |                          |                          |  |
|---------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| a. Taken prescription medication? .....                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |  |
| b. Taken non-prescription medications, including herbal, supplements or other alternative therapies/regimens? ..... | <input type="checkbox"/> | <input type="checkbox"/> |  |
6. Proposed Insured's use of tobacco/nicotine products including (but not limited to) cigarettes, cigars, pipes or any smoking materials, snuff, chewing tobacco, nicotine gum, or nicotine patch is as indicated below:
- Currently uses tobacco/nicotine     Has **never** used tobacco/nicotine products of any form.  
 Has not used tobacco/nicotine products of any form in the past \_\_\_\_ months/\_\_\_\_ years.
7. Does the Proposed Insured consume alcoholic beverages? (If "YES", list type, amount and frequency) .....
- |  |                          |                          |  |
|--|--------------------------|--------------------------|--|
|  | <input type="checkbox"/> | <input type="checkbox"/> |  |
|--|--------------------------|--------------------------|--|
8. Has a parent, brother or sister ever had heart disease, stroke/cerebrovascular disease, cancer or kidney disease? .....
- |  |                          |                          |  |
|--|--------------------------|--------------------------|--|
|  | <input type="checkbox"/> | <input type="checkbox"/> |  |
|--|--------------------------|--------------------------|--|

9.

FAMILY HISTORY	Age (if Living)	Condition of Health	Age (at Death)	Cause of Death
Father				
Mother				
Brothers and Sisters				

It is agreed that all statements and answers given on the Part Two Application are complete and true to the best of my knowledge and belief and shall constitute a part of this application.

Proposed Insured (Signature in full) \_\_\_\_\_ Dated \_\_\_\_\_

Witnessed By \_\_\_\_\_ City, State Where Witnessed \_\_\_\_\_

# MEDICAL EXAMINER'S REPORT

## Section 1 Complete for all paramedicals and MD examinations

1. a. Name of Proposed Insured \_\_\_\_\_

b. Date of Birth (Mo./Day/Yr.) \_\_\_\_\_

2. a. Height (in shoes) \_\_\_\_ ft. \_\_\_\_ in. Did you measure?  YES  NO

b. Weight \_\_\_\_ lbs. Did you weigh?  YES  NO

c. Is appearance unhealthy or older than stated age?  YES  NO

3. Blood Pressure: If there is a history of elevated blood pressure or first reading is 140/90 or more, take two additional readings, spacing them at least 5 minutes apart.

	1st	2nd	3rd
Systolic	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Diastolic	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>

If Proposed Insured is able and pulse rate is less than 50, measure pulse after exercise and 3 minutes later.

4. Pulse: At Rest After Exercise 3 Minutes Later

Rate	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Irregularities/min.	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>

5. Indicate requirement completed or arranged (check as many as apply or none):

- Blood Profile       Treadmill ECG
- ECG                       Urine
- Other (specify) \_\_\_\_\_

Details of "YES" answers (*identify item*) or for comments and your impressions:

### Complete Questions 6-10 if Proposed Insured is age 71 or older.

- |                                                                                                                                                                   | YES                      | NO                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 6. Does the Proposed Insured:                                                                                                                                     |                          |                          |
| a. Use any assistive devices for walking such as a wheelchair, walker, or cane, or have difficulty ambulating or transferring? .....<br>(If yes, provide details) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Drive? .....<br>(If no, when and why did they stop?)                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have a history of falls in the past year? .....<br>(If yes, how many, and provide details)                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Exercise? .....<br>(If yes, what type and how often?)                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Work, Volunteer, Travel? .....<br>(If yes, provide details (type, how often))                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Need any assistance with the following activities:                                                                                                             |                          |                          |
| Bathing .....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Transferring .....                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing .....                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating .....                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Toileting.....                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (If yes, provide details)                                                                                                                                         |                          |                          |
| g. Need any assistance with the following activities:                                                                                                             |                          |                          |
| Cooking .....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| House Cleaning .....                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Laundry .....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Shopping.....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Meal Preparation .....                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Handling Finances .....                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Using the Telephone .....                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Medication .....                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (If yes, provide details)                                                                                                                                         |                          |                          |

