

PART II

# U.S. FINANCIAL LIFE INSURANCE COMPANY

**MEDICAL EXAMINATION**

P.O. Box 2347, Cincinnati, Ohio 45201-2347

1. Full Name of Proposed Insured			2. Date of Birth			
3. Number & Street			4. Amount of insurance for which you are applying.			
5. City	State	Zip Code	6. What is the Insurance Agent's Name?			
7. Family record	Living		Deceased		8. Name of Personal Physician	
	Age	Health	At Age	Cause		
	Father					Number & Street
	Mother					City
	Brothers					State
	Sisters					Zip Code
No. Living				9. What is the date you were last examined, advised or treated?		
No. Dead				Date:	For what reason?	

Give complete information regarding affirmative answers to questions 10 thru 21 under "Details" below. Specify conditions, severity, date, duration, frequency of attacks, aftereffects, and the name and address of each Doctor and of each hospital.

Question	Yes	No	Details
10. Have you ever been rejected for military service, for employment, or for insurance because of medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you ever been in a hospital, clinic, sanitarium or institution for observation, diagnosis, operation, or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
12. During the past 5 years, have you: A. Been treated for alcoholism or drug usage? B. Used any drugs, narcotics or hallucinogens (including LSD, cocaine, marijuana, heroin) except as prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
13. In the past 10 years, have you been treated for or been diagnosed as having any immunological disorder, AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)?	<input type="checkbox"/>	<input type="checkbox"/>	
14. During the past 5 years have you had an x-ray, electrocardiogram, blood study, or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you ever had or been told you had any of the following: A. heart murmur, chest pain, heart attack, anemia, varicose veins, high blood pressure, or any disease or abnormality of the heart, blood or circulatory system? B. dizziness, fainting spells, epilepsy, convulsions, nervous or mental conditions, paralysis, or any disease or abnormality of the brain or nervous system? C. asthma, emphysema, pleurisy, tuberculosis, spitting blood, or any disease or abnormality of the lungs or respiratory system? D. ulcer, hernia, or any disease or abnormality of the stomach, intestines, liver, gallbladder, bowels, rectum, pancreas, or spleen? E. albumin, sugar, or blood in the urine, kidney stones, or any disease or abnormality of the kidneys, urinary system, or of the male or female organs? F. arthritis, rheumatism, rheumatic fever, or any disease or abnormality of the back, spine, bones, joints or muscles? G. diabetes, gout, goiter, or any disease or abnormality of the glands? H. cancer or tumor? I. any disease or abnormality of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Do you now have any abnormality, deformity, disease, or disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Are you receiving treatment or taking medication of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	
18. In the past 5 years, have you consulted, or been treated, or been examined by any physician or practitioner. A. not named above? B. for any cause not recorded above?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Have you lost 10 or more pounds during past 12 months? (give amount)	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you used any tobacco products within the past 12 months? If "yes", please indicate type of product used (cigarettes, pipe, cigar, snuff, etc.).  Type _____	<input type="checkbox"/>	<input type="checkbox"/>	
21. Additional questions if applicable A. Have you ever had or been told you had any cancer or tumor, or disease of the breast or female organs, menstrual irregularity, or complications of pregnancy? B. Are you now pregnant? (if "yes", how long?)	<input type="checkbox"/>	<input type="checkbox"/>	

I represent that all statements and answers made in this Part II of this application are full, complete and true to the best of my knowledge and belief. It is agreed that the above questions and answers shall form Part II of my pending application for insurance, and also of any subsequent application by me for insurance in this Company unless I then undergo another medical examination which by its terms is made a part of such application and subsequent applications.

Dated this \_\_\_\_\_ Day of \_\_\_\_\_ 19\_\_\_\_\_

\_\_\_\_\_  
Witness

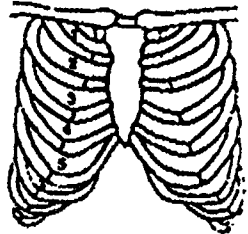
\_\_\_\_\_  
Signature of Proposed Insured

# U.S. FINANCIAL LIFE INSURANCE COMPANY

PART III

P.O. Box 2347, Cincinnati, Ohio 45201-2347

<p><b>1. Measurements</b></p> <p>A. Height in shoes _____ ft. _____ ins.</p> <p>B. Weight without coat _____ lbs.</p> <p>C. Chest-forced inspiration _____ ins.</p> <p>D. Chest-forced expiration _____ ins.</p> <p>E. Abdomen at umbilicus _____ ins.</p>	<p><b>2. Pulse Seated.</b></p>	<p><b>3. Is Pulse rate irregular or intermittent?</b></p> <p><input type="checkbox"/> Yes      If "yes", describe and give frequency per minute.</p> <p><input type="checkbox"/> No</p>	<p><b>4. Blood pressure. With history of hypertension if the first reading exceeds 140 systolic or 90 diastolic, take two additional readings at intervals.</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">1st</td> <td style="width: 10%; text-align: center;">2nd</td> <td style="width: 10%; text-align: center;">3rd</td> </tr> <tr> <td style="text-align: center;">Systolic</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Diastolic 5th phase</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			1st	2nd	3rd	Systolic					Diastolic 5th phase																																																
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<p><b>5. Does examination reveal any abnormality of:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%;"><b>A. the heart and blood vessels?</b></td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> </tr> <tr> <td>    Is there a murmur?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>B. the lungs and respiratory system?</b></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    any areas of tenderness or masses?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>    any enlargement of the liver or spleen?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>D. the brain or nervous system?</b></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    are the knee jerks absent?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>    are the pupillary reactions abnormal?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>E. the skin, breasts, ears, eyes or throat?</b></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p><b>7. Is there any enlargement of the thyroid?</b></p> <p>    Is it symmetrical, asymmetrical, nodular, diffuse?</p> <p><input type="checkbox"/>      <input type="checkbox"/>      <input type="checkbox"/></p> <p><b>8. Are the lymph nodes enlarged? Describe</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>9. Is there a hernia?</b></p> <p>    Was it ever strangulated?</p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>10. Is there evidence of varicose veins or ulcers?</b></p> <p>    Do they extend above the knee?</p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>11. Is the Proposed Insured lame, deformed, or maimed? Describe.</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>12. Does the Proposed Insured appear older than stated age?</b></p> <p>    (If "yes", give apparent age _____)</p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>13. Does the Proposed Insured appear to have any health problems?</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>14. Has the Proposed Insured ever been one of your patients?</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>15. Are you aware of anything about the health, habits, environment, or mode of living of the Proposed Insured which might have an unfavorable affect on his or her insurability?</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>16. Are you related in any way to the Proposed Insured or to the agent?</b></p> <p><input type="checkbox"/>      <input type="checkbox"/></p> <p><b>17. Use this section to provide details of "yes" answers:</b></p>	<b>A. the heart and blood vessels?</b>		Yes	No	Is there a murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>B. the lungs and respiratory system?</b>				any areas of tenderness or masses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	any enlargement of the liver or spleen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>D. the brain or nervous system?</b>				are the knee jerks absent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	are the pupillary reactions abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>E. the skin, breasts, ears, eyes or throat?</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>6. Heart:</b></p> <p><b>A. Is there evidence of:</b></p> <table style="width: 100%;"> <tr> <td>enlargement</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>dyspnea</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>edema</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> <p><b>B. Is there a murmur?</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <table style="width: 100%;"> <tr> <td style="text-align: center;"><u>Timing</u></td> <td style="text-align: center;"><u>Intensity</u></td> <td style="text-align: center;"><u>Quality</u></td> </tr> <tr> <td><input type="checkbox"/> systolic</td> <td><input type="checkbox"/> faint</td> <td><input type="checkbox"/> soft</td> </tr> <tr> <td><input type="checkbox"/> presystolic</td> <td><input type="checkbox"/> moderate</td> <td><input type="checkbox"/> blowing</td> </tr> <tr> <td><input type="checkbox"/> diastolic</td> <td><input type="checkbox"/> loud</td> <td><input type="checkbox"/> rough</td> </tr> </table> <p><b>C. Does exercise affect murmur?</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><b>D. Is murmur transmitted?</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><b>E. Locate apex by . . . . . X</b></p> <p>    Point of greatest intensity ●</p> <p style="text-align: right;">Outline murmur by direction of transmission by → ○</p> <p><b>F. What is your impression of the murmur?</b> _____</p> <p>_____</p> <p>_____</p>	enlargement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	dyspnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	edema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Timing</u>	<u>Intensity</u>	<u>Quality</u>	<input type="checkbox"/> systolic	<input type="checkbox"/> faint	<input type="checkbox"/> soft	<input type="checkbox"/> presystolic	<input type="checkbox"/> moderate	<input type="checkbox"/> blowing	<input type="checkbox"/> diastolic	<input type="checkbox"/> loud	<input type="checkbox"/> rough
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Mail Examination Directly To the Home Office, Do Not Release To The Applicant Or To The Agent

I Have Examined \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_ 19\_\_\_\_ At \_\_\_\_\_ O'Clock \_\_\_\_\_ PA

Name Of Person Examined \_\_\_\_\_

My Office       \_\_\_\_\_

Examination Was Made At \_\_\_\_\_ M

Do Not Detach

**AUTHORIZATION**

I hereby authorize: any licensed physician; any medical practitioner, any hospital; and clinic; and medical or medically related facility; any insurance company; the Medical Information Bureau; or any other association, institution or person; to give to the U.S. Financial Life Insurance Company any information which they may have concerning me or my health. A photostatic copy of this shall be as valid as the original.

Dated this \_\_\_\_\_ Day of \_\_\_\_\_ 19\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

Do Not Detach

**MEDICAL EXAMINATION FEE VOUCHER**

Please Print, Type, or Stamp

Person examined \_\_\_\_\_ M.D.

Date of examination \_\_\_\_\_ Examiner's Name \_\_\_\_\_

\_\_\_\_\_ Mailing Address \_\_\_\_\_

Insert your fee: \$ \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Tax I.D./Social Security Number \_\_\_\_\_

**NOTICE AND CONSENT FOR BLOOD TESTING  
WHICH INCLUDES AIDS VIRUS (HIV) ANTIBODY TESTING**

To determine your insurability, the insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory. A test will be performed to determine the presence of antibodies 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 series consists of two ELISA tests followed by a Western Blot test. The test is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or 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 such as its affiliates, reinsurers, employees, or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies is other than normal, the insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV antibody 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 a 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 antibody test result is normal, no routine notification will be sent to you. If the HIV antibody test result is other than normal, the insurer 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 or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

A positive HIV antibody test result does 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 positive should be considered infected with the AIDS virus and capable of infecting others. A negative HIV antibody test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not necessarily mean that you have not been infected with the virus.

A positive HIV antibody test result 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.

Additional information concerning the meaning of the test and the interpretation of the results of the test may be obtained from a private physician, the County Department of Health, the State Department of Health Services, local Medical Societies, or Alternative Test Sites.

I have read and I understand this Notice and Consent for Blood Testing Which Includes AIDS Virus (HIV) Antibody Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the 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. This authorization is valid for six months.

NAME OF PROPOSED INSURED (PLEASE PRINT)		BIRTHDATE
SIGNATURE OF PROPOSED INSURED	DATE SIGNED	STATE OF RESIDENCE <b>CALIFORNIA</b>

32-2950 (California - Northern)

Copy 1 - Insurer    Copy 2 - Proposed Insured