



UNION NATIONAL LIFE INSURANCE COMPANY

BATON ROUGE, LOUISIANA

District No. _____

Use Black Ink.

STATEMENT OF MEDICAL EXAMINER

EVERY QUESTION MUST BE ASKED BY THE MEDICAL EXAMINER AND THE ANSWERS RECORDED IN INK IN THE EXAMINER'S OWN HANDWRITING. PLEASE PRINT NAMES AND ADDRESSES. THE PROPOSED INSURED MUST SIGN IN THE EXAMINER'S PRESENCE. EXAMINATIONS MUST BE MADE IN PRIVATE.

Part Two of Application

1. Full Name of Proposed Insured		Name of Employment Candidate		Birthdate	3. Age		
4. Family Record	LIVING		DEAD		6 a. Have you smoked one or more cigarettes within the last 12 months? b. Have you been a cigarette smoker within the past 10 years?	YES	NO
	Age	State of Health	Age at Death	Cause of Death		<input type="checkbox"/>	<input type="checkbox"/>
	Father					<input type="checkbox"/>	<input type="checkbox"/>
	Mother					<input type="checkbox"/>	<input type="checkbox"/>
	Brothers and Sisters					<input type="checkbox"/>	<input type="checkbox"/>
No Living					<input type="checkbox"/>	<input type="checkbox"/>	
No Dead					<input type="checkbox"/>	<input type="checkbox"/>	
5. Have any of your parents, brothers, or sisters ever had heart disease, diabetes, or mental illness?				YES	NO	<input type="checkbox"/>	<input type="checkbox"/>
				9. In the past 10 years, have you been treated for alcoholism or any drug habit?		<input type="checkbox"/>	<input type="checkbox"/>

Give complete information regarding "Yes" answers to questions 5 thru 17, under "Details" below. Specify conditions, severity, date, duration, frequency of attacks, aftereffects, and name and address of each doctor and of each hospital.

10. In the past 5 years, have you been in a hospital, clinic, sanitarium, or institution for examination, observation, diagnosis, operation, or treatment?	YES	NO	17. In the past 10 years have you: a. Had or been told you had Acquired Immune Deficiency Syndrome, ("AIDS"), or AIDS Related Complex (ARC)? b. Ever tested positive on an AIDS-related blood test?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
11. In the past 5 years, have you had an X-ray, electrocardiogram, blood study, or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	Details		
To the best of your knowledge and belief:					
12. In the past 10 years, have you been told you had:	<input type="checkbox"/>	<input type="checkbox"/>			
a. dizziness, fainting spells, epilepsy, nervous breakdown, severe headaches, or any disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>			
b. asthma, hay fever, chronic cough, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>			
c. high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>			
d. any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver, or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>			
e. nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>			
f. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?	<input type="checkbox"/>	<input type="checkbox"/>			
g. anemia, goiter, or any disease or disorder of the blood or glands?	<input type="checkbox"/>	<input type="checkbox"/>			
h. rheumatic fever, diabetes, or sugar, albumin, or blood in the urine?	<input type="checkbox"/>	<input type="checkbox"/>			
i. cancer, or a tumor or ulcer of any kind, or venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>			
j. varicose veins, phlebitis, or a hernia of any kind?	<input type="checkbox"/>	<input type="checkbox"/>			
k. any disease or disorder of the eyes, ears, nose, or throat?	<input type="checkbox"/>	<input type="checkbox"/>			
13. a. have you now any abnormality, deformity, disease, or disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
b. are you receiving treatment or taking medication of any kind?	<input type="checkbox"/>	<input type="checkbox"/>			
14. a. When did a physician or practitioner last examine, advise, or treat you?					
Name _____ Date _____					
Address _____					
b. Give reason for and results of consultation.					
15. In the past 5 years, have you consulted or been treated or examined by any physician or practitioner (a) not named above?	<input type="checkbox"/>	<input type="checkbox"/>			
(b) for any cause not recorded above?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Have you lost 10 or more pounds during past 12 months? (give amount)	<input type="checkbox"/>	<input type="checkbox"/>			

I hereby represent that all statements and answers as written or printed herein and in my Application are full, complete and true to the best of my knowledge and belief, whether written by my own hand or not, and that this Medical History shall be a part of the application for life insurance on my life.

Dated at _____ this _____ day of _____, 19 _____

Witness _____
Medical Examiner

Signature of Proposed Insured
(Applicant if Proposed Insured is under 15)

