

Part Two Application
UNITED INSURANCE COMPANY OF AMERICA
 CHICAGO, ILLINOIS 60601
 Answers Made to Medical Examiner or to Agent if Non-Medical

Proposed Insured _____	Birth Date _____						
<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">First Name</td> <td style="width:33%; border: none;">Middle Initial</td> <td style="width:33%; border: none;">Last Name</td> </tr> </table>	First Name	Middle Initial	Last Name	<table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;">Month</td> <td style="width:33%; border: none;">Day</td> <td style="width:33%; border: none;">Year</td> </tr> </table>	Month	Day	Year
First Name	Middle Initial	Last Name					
Month	Day	Year					

1. a. Name and address of your personal physician? _____
 (If none, so state)
 b. Date and reason last consulted? (If within 10 years) _____
 c. What treatment was given or medication prescribed? _____

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 2. Have you ever been treated for or ever had any known indication of: | Yes | No |
| a. Disorder of eyes, ears, nose or throat? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disease? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disease of the stomach, intestines, liver or gallbladder? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes; thyroid or other endocrine disorders? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity, lameness or amputation? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor, or cancer? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorder of the blood? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco, or any habit-forming drugs? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now under observation or taking treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any change in weight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other than above, have you within the past 5 years: | | |
| a. Had a checkup, consultation, illness, injury, surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic, sanatorium, or other or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if Living?	Cause of Death	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living.			
No. Dead.			

- | | | |
|------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 9. Females only: | Yes | No |
| a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. To the best of your knowledge and belief are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

I declare on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, that each of the above answers is full, complete, and true, to the best of my knowledge and belief and that to the best of my knowledge and belief I am in good health and a proper subject for life insurance. To the extent permitted by statute, I expressly waive, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which be thereby acquired.

Dated at _____ this _____ day of _____, Year _____

Witness _____
 Form 500-10-68 (Rev. 9/86) Signature of Proposed Insured in full _____

AUTHORIZATION

By this form (or copy of it) I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the UNITED INSURANCE COMPANY OF AMERICA or its reinsurers any such information.

Date _____, Year _____

MEDICAL EXAMINER'S REPORT

10. a.	Height (In shoes) ft. in.	Weight (Clothed) lbs.	Males Only:			Details of "Yes" answers. (Identify item.)
			Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No						
c. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No						
11. Blood Pressure (Record ALL readings)						
Systolic						
Diastolic		{	4th Phase			
			5th Phase			
12. Pulse:						
Rate		At Rest	After Exercise	3 Minutes Later		
Irregularities per min.						
13. Heart: Is there any:						
Enlargement		<input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Murmur(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Edema		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(describe below—if more than one, describe separately)						
Location	<input type="checkbox"/>	<input type="checkbox"/>				
Constant	<input type="checkbox"/>	<input type="checkbox"/>				
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>				
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>				
Localized	<input type="checkbox"/>	<input type="checkbox"/>				
Systolic	<input type="checkbox"/>	<input type="checkbox"/>				
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>				
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>				
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>				
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>				
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>				
After Exercise:						
Increased		<input type="checkbox"/>				
Absent		<input type="checkbox"/>				
Unchanged		<input type="checkbox"/>				
Decreased		<input type="checkbox"/>				
			Indicate:			
			Apex by	X		
			Murmur area by	O		
			Point of greatest intensity by	O		
			Transmission by	↓		
For comments and your impression?						
14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)						
					Yes	No
(a) Eyes, ears, nose, mouth, pharynx?					<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)						
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ...					<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?					<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?					<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?					<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system (include prostate)?					<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?					<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?					<input type="checkbox"/>	<input type="checkbox"/>
15. (a) Are there any hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Any hemorrhoids? <input type="checkbox"/> Yes <input type="checkbox"/> No						
16. Are you aware of additional medical history?						
(A confidential report may be sent to the Medical Director)						
17. (a) Urinalysis: Specific Gravity			Albumin	Sugar	Send Specimen To Lab If:	
(b) Is specimen being sent to Lab One? <input type="checkbox"/> Yes <input type="checkbox"/> No					1. Amount \$50,000 or more	
OUR LAB ONE ACCOUNT IS #ACF					2. Age over 60.	
					3. Renal disease or marked hypertension in history or found on examination.	

THIS FORM IS FOR UNITED INSURANCE COMPANY OF AMERICA ONLY—PLEASE COMPLETE POLICY NUMBER WHEN EXAM COMPLETED.

Name of Sales Representative _____ District No. _____ Agency No. _____

THIS EXAMINATION MUST BEAR THE DATE AND TIME OF DAY ACTUALLY BEGUN.

I certify that the above is a record of a careful examination of _____
my office

made at his place of business at _____ Time _____ A.M. on _____, year _____
his home

Signature of Examiner _____ Address _____

(Rev. 11/99) City & State _____