Statements to Examiner

United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Omaha, Nebraska

Proposed Insured	First Name	Middle Initial	Last Name	Maiden Name/Former Name	Birth Date	Month	Day	Year
Street Address	City	State	ZIP Code		Social Security Number			

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

	Yes	No
2. Within the last 10 years, have you been treated for or had any known indication of:		
(a) Disorder of eyes, ears, nose or throat?	☐	☐
(b) Paralysis or stroke; mental, nervous or emotional disorder; chronic fatigue syndrome; dizziness or fainting; convulsions or frequent headaches?	☐	☐
(c) Bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder; shortness of breath, persistent hoarseness or cough; or blood spitting?	☐	☐
(d) Chest pain or any type of chest discomfort or distress; rapid or irregular heart action; high blood pressure; rheumatic fever; heart murmur; heart attack; or any disorder of the heart or blood vessels?	☐	☐
(e) Jaundice or hepatitis; intestinal bleeding; ulcer; hernia; appendicitis; colitis; diverticulitis; hemorrhoids; recurrent indigestion or other disorder of the stomach, intestines, liver, pancreas, or gallbladder?	☐	☐
(f) Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
(g) Diabetes; thyroid or other endocrine disorders?	☐	☐
(h) Neuritis; sciatica; rheumatism; arthritis; fibromyalgia; gout or disorder of the muscles or bones, including the neck, spine, back or joints?	☐	☐
(i) Deformity, lameness or amputation?	☐	☐
(j) Allergies or any disorder of the skin?	☐	☐
(k) Enlarged lymph glands?	☐	☐
(l) Anemia or other disorder of the blood?	☐	☐
(m) Cancer, polyp, cyst or any tumor?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐

	Yes	No
4. Has your weight changed more than 10 pounds in the past year?	☐	☐
5. *Other than above*, have you within the past five years:		
(a) Had any mental or physical disorder not listed above?	☐	☐
(b) Had a checkup, consultation, illness, injury or surgery?	☐	☐
(c) Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐
(d) Had electrocardiogram, X-ray or other diagnostic test?	☐	☐
(e) Been advised to have any diagnostic test (excluding an HIV test), hospitalization or surgery which was not completed?	☐	☐
6. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or licensed practitioner?	☐	☐
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
7. (a) Do you use drugs, except as prescribed by a physician?	☐	☐
(b) Do you use alcoholic beverages? (If (a) or (b) answered "Yes," give type, quantity and frequency.)	☐	☐
8. Have you ever received or been advised to have counseling or treatment for alcohol or drug use?	☐	☐
9. Have you used any form of tobacco in the last five years? (If "Yes," check form(s), and if currently not using tobacco, advise the date discontinued.) ____/____/____	☐	☐

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other
Number per day ____

DETAILS of "Yes," answers. **Identify question number: Circle Applicable Items:** Including diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.

10. Family History: tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ☐ Yes ☐ No

	Age, if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters Number Living? Number Dead?			

I agree that these statements are a part of my application and that all statements and answers: (a) are complete and true to the best of my knowledge and belief; and (b) will be relied on to determine my insurability.

Dated at ____ this ____ date of ____ year ____

Witness ____ ____

Signature of Examiner Signature of Proposed Insured

MLU21727-04

Confidential Medical Report

Mail Direct to: Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

10.

(a) Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only		
		Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

(b) Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No
(c) Is appearance unhealthy or older than stated age? ☐ Yes ☐ No
(d) Was blood drawn? ☐ Yes ☐ No Last name of applicant ____________

11. Blood Pressure (Record ALL readings.) Repeat readings if elevated.

Systolic			
Diastolic fourth phase			
Diastolic fifth phase			

12. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart:
Is there any:
Enlargement? ☐ Yes ☐ No Dyspnea? ☐ Yes ☐ No
Murmur(s)? ☐ Yes ☐ No Edema? ☐ Yes ☐ No
(Describe below — if more than one, describe separately.)

	Murmur No. 1	Murmur No. 2
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by X
Murmur area by
Point of greatest intensity by O
Transmission by

MCL

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? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (include scars); varicose veins or peripheral arteries?	☐	☐
(c) Lymph nodes?	☐	☐
(d) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(e) Respiratory system?	☐	☐
(f) Abdomen (include scars)?	☐	☐
(g) Genitourinary system (include prostate)?	☐	☐
(h) Endocrine system (include thyroid and breasts)?	☐	☐
(i) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
(j) Any hernias?	☐	☐
Any hemorrhoids?	☐	☐
15. Are you aware of additional medical history? *(A confidential report may be sent to the Medical Director.)*	☐	☐
16. Did your examination reveal any condition requiring further investigation or immediate treatment?	☐	☐

(If "Yes," did you advise the Proposed Insured or refer the Proposed Insured to his or her personal physician? ☐ Yes ☐ No)

Details of "Yes" answers (identify item).

Only tests (EKG, X-ray, etc.) authorized by the agent or Home Office will be paid.

Time of examination ________ a.m. ________ p.m.
Place: ☐ Your office
☐ Other (Explain)
____

Amount of Insurance $ ____________
Name of Agent ____________ Print
Agency Name ____________ Print

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to Home Office? ☐ Yes ☐ No

IMPORTANT: If life insurance coverage applied for, forward specimen of urine to Home Office if: (a) albumin, sugar or blood is found; (b) there is a history of albumin or sugar in urine, renal disease, heart trouble or high blood pressure; (c) applicant is over age 55; and (d) age 0-45 and amount exceeds $200,000 or if age 46-55 and amount exceeds $100,000.

Please PRINT name and address in full in addition to your signature. Fee $ ________ Tax I.D. Number ____________

EXAMINER ____________ Please Print Name ____ Title **SIGNATURE** ____________ Title

ADDRESS ____________ Number and Street ____ City ____ State ____ ZIP Code ____ Date ____ Year

MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY
UNITED WORLD LIFE INSURANCE COMPANY

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
☐ ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

THE HIV ANTIBODY TEST

To evaluate your Insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous three-six months.

MEANING OF TEST RESULTS

Positive HIV antibody/antigen test results do 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/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

COUNSELING

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or your own health care provider. A list of counseling resources is provided for your information.

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician

____

Address

____

____

CONSENT

I have read and I understand this Notice and Consent form. I voluntarily consent to testing as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date______________________ ______________________

Signature of Proposed Insured or Parent/Guardian