

Universal Guaranty Life Insurance Company
Springfield, IL

Proposed Insured _____
First Name Middle Name Last Name

Birth Date _____ D.L. # _____
Month Day Year

1. Name and address of your personal physician _____
(If none, so state)

Date and reason last consulted _____

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, paralysis, stroke, speech defect, or mental/nervous disorder? | <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 attack or other disorder 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 disorder 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, cancer, ulcers or phlebitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies, anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for antibodies to the AIDS virus (Human T-Cell Lymphotropic, Type III, HIV Virus)? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Do you currently use alcoholic beverages in any form? If yes, state kind and daily, weekly or monthly amount. | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| 3. In the past 5 years, have you used? | Yes | No |
| a. Barbiturates, sedatives or tranquilizers habitually? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. L.S.D., marijuana or other similar agents? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heroin, morphine or other narcotic drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever been treated for alcoholism or any drug habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now under observation or taking treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any change in weight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you used tobacco in any form in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other than above, have you within the past 5 years: | | |
| a. Had any mental or physical disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury or surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had electrocardiogram, X-ray or other diagnostic tests? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In your family history, has there been treatment or diagnosis of: tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE PROVIDE DETAILS of "Yes" answers on the reverse side of form. (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 & Sisters			
Number Living			
Number Deceased			

WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

So far as I know and believe, the answers given above are true and complete. I agree that they, with the statements in my application, will be the basis for and a part of any insurance issued.

WITNESSED _____ SIGNED _____ DATE _____
Medical Examiner Proposed Insured

PART II ADULT MEDICAL APPLICATION MEDICAL EXAMINER'S REPORT

<p>11. Female only: Yes No</p> <p>a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. To the best of your knowledge and belief are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Details of "Yes" answers. (Identify item).																																																																																																								
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<p>16. Is there on examination any abnormality of the following: (Circle applicable items and give details.)</p> <table style="width: 100%;"> <tr> <td style="width: 60%;">(a) Eyes, ears, nose, mouth, pharynx</td> <td style="width: 10%;">Yes</td> <td style="width: 10%;">No</td> <td style="width: 20%;"></td> </tr> <tr> <td>(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(c) Nervous system (include reflexes, gait, paralysis)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(d) Respiratory system?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(e) Abdomen (include scars)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(f) Genitourinary system (include prostate)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(g) Endocrine system (include spine, joints, deformities and amputations)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>(h) Musculoskeletal system (include spine, joints, deformities and amputations)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </table> <p>17. (a) Any hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Hemorrhoids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Are you aware of additional medical history? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;"><i>(A confidential report may be sent to the Medical Director)</i></p>		(a) Eyes, ears, nose, mouth, pharynx	Yes	No		(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 spine, joints, deformities and amputations)?	<input type="checkbox"/>	<input type="checkbox"/>		(h) Musculoskeletal system (include spine, joints, deformities and amputations)?	<input type="checkbox"/>	<input type="checkbox"/>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Urinalysis:</td> <td style="width: 50%;">Albumin</td> </tr> <tr> <td>Specific Gravity</td> <td>Sugar</td> </tr> <tr> <td colspan="2">Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2">Send Specimen to Home Office if: <i>(Details according to Company)</i></td> </tr> </table>	Urinalysis:	Albumin	Specific Gravity	Sugar	Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No		Send Specimen to Home Office if: <i>(Details according to Company)</i>																																																																
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MEDICAL EXAMINER:

Name (Please Print) _____ Signature _____ Date _____

Address _____

Medical School _____ Date of Graduation _____ Birthdate _____

THIS COMPLETED FORM MUST BE SENT DIRECTLY TO THE HOME OFFICE BY THE MEDICAL EXAMINER

ExamOne

NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Insurer: _____

THE HIV ANTIBODY TEST

To evaluate your insurability, the Insurer named above has requested that you provide a specimen sample of your blood, urine or saliva 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 medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, it 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 infection occurred within the previous 3-6 months prior to the test.

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

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NOTIFICATION OF TEST RESULTS

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 result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.

Name of

Physician: _____

Address _____

CONFIDENTIALITY OF TEST RESULTS

All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. No other disclosure will be made of the results except as required by law.

CONSENT

I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and 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.

Name of Proposed Insured (Please Print)

Date

Signature of Proposed Insured

Address