

Name of Proposed Insured	Birthdate			Sex	Name of Account Executive
	Mo.	Day	Yr.		

1. Name and address of personal physician?	a. Date last seen?	b. For what reason?
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MEDICAL HISTORY (TO BE RECORDED BY MEDICAL EXAMINER):	YES	NO
So far as you know and believe —		
2. Have you ever had any physical disability or impairment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is any prescription medication being taken? (If yes, what?)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been treated for or ever had any indication of:		
a. Coronary artery disease, chest pain, shortness of breath, abnormal heart rate or rhythm; rheumatic fever or heart murmur; high blood pressure or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
b. Disease or disorder of lungs or bronchi, such as tuberculosis (or exposed to tuberculosis), pleurisy, chronic cough, asthma or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
c. Disease or disorder of esophagus, stomach, intestinal tract, such as diarrhea, abdominal pain, ulcer, intestinal bleeding or hemorrhoids; jaundice, liver or gall bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>
d. Disease or disorder of kidneys, ureters, or bladder; sugar, albumin, pus, blood or casts in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
(i) (MALE) Disease or disorder of prostate or testicles?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) (FEMALE) Disease or disorder of breasts, uterus, tubes, ovaries; abnormal menstruation or pregnancies; presently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of brain or nervous system, such as headaches, dizziness or unconsciousness?	<input type="checkbox"/>	<input type="checkbox"/>
f. Mental illness, convulsion, epilepsy, paralysis, neuralgia, neuritis or sciatica?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes; thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Disease or disorder of skin, lymph glands, muscles, bones or joints, arthritis, gout, back or neck disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Disease or disorder of eye or ear?	<input type="checkbox"/>	<input type="checkbox"/>
j. Tumor, cancer, unexplained infection or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you:		
a. Had weight gain <input type="checkbox"/> or loss <input type="checkbox"/> in past year? (If yes, how much)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Used alcohol or drugs (except as prescribed by a physician)? State which, amounts, and frequency	<input type="checkbox"/>	<input type="checkbox"/>
c. Been discharged or rejected from military service for medical or physical condition?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had electrocardiogram, X-ray, other diagnostic test (not including HIV tests or studies) within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Had any other examination or treatment not specified above, by a physician, hospital, clinic or institution within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you used any form of nicotine/tobacco or nicotine substitutes? If Yes: Date of last use _____ Type _____ Quantity _____ (month/year)	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there a history in parents, brothers or sisters of diabetes, heart or kidney disease, tuberculosis, cancer or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
8.		

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

Family Record	Age if Living?	Cause of Death	Age at Death?
Father			
Mother			
Siblings			

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

Medical Examiner (WITNESS)	Proposed Insured	Date
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EXAMINATION OF:
(Print full name)

Examination Made At Examiner's Office
 Other
 AM PM Last Meal AM PM

10. Height		11. Weight		12. Males Only		
Ft.	In.	Present	1 Yr. Ago	Chest Insp.	Chest Exp.	Girth Abdomen
13. Blood Pressure		Systolic	Diastolic	IF BLOOD PRESSURE IS ABNORMAL — TAKE 2 ADDITIONAL READINGS		14. Pulse Temp.
1st Reading						
2nd Reading						
3rd Reading						

15. URINALYSIS	Specific Gravity	Albumin	Sugar

16. ADDITIONAL STUDIES:
 Urine Specimen Required Blood Profile
 EKG CXR
 a. Are you satisfied specimens are authentic? Yes No
 NOTE: Send completed exam form, EKG tracing and CXR film to Universal Underwriters Insurance Company, 7045 College Blvd., Overland Park, KS 66211-1523. Send specimens to OSBORN

TO BE COMPLETED BY PHYSICIAN

On inquiry and examination, is there evidence of —

	YES	NO
1. Present or past diseases or abnormalities of:		
a. Brain, nervous system? (Test reflexes; coordination) . . .	<input type="checkbox"/>	<input type="checkbox"/>
b. Eyes, ears, nose, throat, teeth, gums?	<input type="checkbox"/>	<input type="checkbox"/>
c. Thyroid or lymph glands?	<input type="checkbox"/>	<input type="checkbox"/>
d. Lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdominal organs?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. Skin or skeletal structure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Hernia? (If yes, describe)	<input type="checkbox"/>	<input type="checkbox"/>
3. Varicose veins or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
4. Arteriosclerosis; other peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Present or past diseases or abnormalities of heart or blood vessels? (If yes, complete questions 8 through 10.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you any pertinent information affecting the proposed insured not brought out above?	<input type="checkbox"/>	<input type="checkbox"/>
7. Will the proposed insured be returning to you for any follow-up visits, or has he been referred to another physician?	<input type="checkbox"/>	<input type="checkbox"/>

Please Give Full Details of Adverse Findings

REQUIRED WHEN QUESTION 5 IS ANSWERED "YES"

8. a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis? YES NO

b. Is there hypertrophy? (If yes, state degree) YES NO

c. Is there a murmur? YES NO

Type: Systolic Diastolic Presystolic

Quality: Soft Rough Blowing

Intensity: Faint (Gr. 1-2) Moderate (Gr. 3-4) Loud (Gr. 5-6)

Location: Apex Base

d. Is murmur constant? YES NO

e. Is murmur transmitted? YES NO

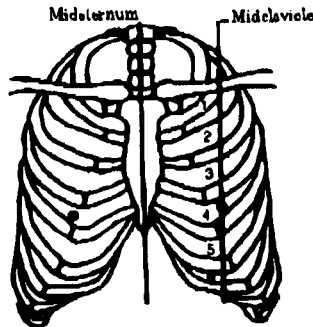
f. If yes, where? _____

9. Exercise Test	Pulse Rate	Irregularities	Murmur	
			Present	Absent
50 vigorous hops		No. per Minute		
Before Exercise				
Immediately After				
3 Minutes After				

10. PLEASE RECORD FINDINGS, USING FOLLOWING SYMBOLS:

Position of apex beat X
 (____ ins. or ____ cms. from midsternum in ____ interspace)

Murmur:
 Area of distribution □
 Point of greatest intensity ○
 Direction of transmission: ↗ . . .



MEDICAL EXAMINER:

Please print name _____ Signature _____ Date _____
 Address _____
 Medical School _____