MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

Name	USAA #
D.O.B. Mo. | Day | Yr.	Contract #

Details of "Yes" answers. (Identify item.)

Identification: ☐ Driver's License ☐ Other ______________________

1. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	ABDOMEN AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No
Weight change in past year? _________ lbs. ☐ Gain ☐ Loss

2. Blood Pressure (Record all readings)	INITIAL READING	FOLLOW UP READING IF NEEDED
Systolic		
Diastolic		

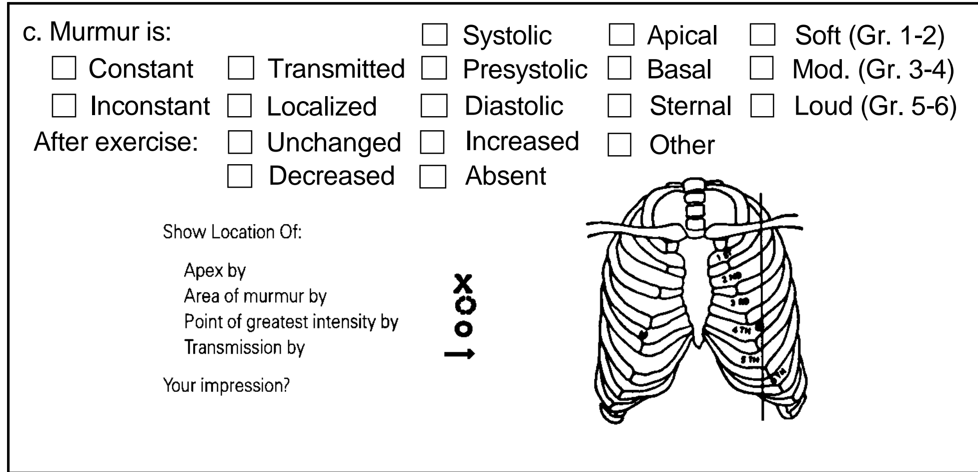
If initial BP Reading exceeds 129 Systolic, or 79 Diastolic. Complete 1 Addtional BP Reading.

3. Resting Pulse:
Rate ______________________
Irregularities Per Min.

4. Heart:
a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No
b. Is murmur present? ☐ Yes ☐ No (If yes, complete 4c)

c. Murmur is:

		☐ Systolic	☐ Apical	☐ Soft (Gr. 1-2)
☐ Constant	☐ Transmitted	☐ Presystolic	☐ Basal	☐ Mod. (Gr. 3-4)
☐ Inconstant	☐ Localized	☐ Diastolic	☐ Sternal	☐ Loud (Gr. 5-6)
After exercise:	☐ Unchanged	☐ Increased	☐ Other	
	☐ Decreased	☐ Absent		



5. Is there on examination any abnormality of the following: (Check 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 (incl. scars); lymph nodes; blood vessels?	☐	☐
c. Nervous system (include reflexes, gait)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6. Are there any hernias?	☐	☐
7. Have you any pertinent information not brought out above?	☐	☐

8. Urinalysis:	SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?

I certify that I made this examination on the ________________ day of ______________ Year __________

Examiner's signature: ________________________ Address ______________________
City ______________________
Examiner's name (print) ________________________ State ______________ Zip Code __________

PLEASE SIGN AND RETURN THIS FORM. **We must have the following document completed and signed before your application can be processed.**

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific blood test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the 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.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent for Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of blood, and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

______________________________	______________	______________
Proposed Insured	**Date of Birth**	**USAA Number**
______________________________	______________	______________
Signature of Proposed Insured or Parent/Guardian	**Date**	**State of Residence**

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to:______________________________

Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Facility Name:______________________________

Address:______________________ ______

____

To release any and all records and information regarding:

Patient's Name:______________________________

First Middle Last

Other Names Used:______________________________

Date of Birth:____________ Social Security Number:______________________

Specifics to be released:______________________________

To be released to and exchanged between the insurance company first named above, and:

EMSI
P.O. Box 2505
Waco, Texas 76702-2505

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of EMSI in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

Signature of patient/guardian/personal representative: ______________________________ **Date:**______________

Legal relationship to applicant:______________________________
(Only if signed above by guardian or personal representative)

Witness signature:______________________ ☐ **Witness Required (only if marked)**
(Only if required)

Notary signature:______________________ ☐ **Notary Required (only of marked)**
(Only if required)

Rev. 05/14/03