

MEDICAL EXAMINER'S REPORT

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

Name	USAA #	Details of "Yes" answers. (Identify item.)
D.O.B. Mo. Day Yr.	Contract #	

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

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:

<input type="checkbox"/> Constant	<input type="checkbox"/> Transmitted	<input type="checkbox"/> Systolic	<input type="checkbox"/> Apical	<input type="checkbox"/> Soft (Gr. 1-2)
<input type="checkbox"/> Inconstant	<input type="checkbox"/> Localized	<input type="checkbox"/> Presystolic	<input type="checkbox"/> Basal	<input type="checkbox"/> Mod. (Gr. 3-4)
After exercise:		<input type="checkbox"/> Diastolic	<input type="checkbox"/> Sternal	<input type="checkbox"/> Loud (Gr. 5-6)
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Increased	<input type="checkbox"/> Other		
<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent			

Show Location Of:

Apex by _____
 Area of murmur by _____
 Point of greatest intensity by _____
 Transmission by _____
 Your impression? _____

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.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (incl. scars); lymph nodes; blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen?	<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"/>

6. Are there any hernias? YES NO

7. Have you any pertinent information not brought out above? YES NO

8. Urinalysis: SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?
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I certify that I made this examination on the _____ day of _____ Year _____

Examiner's signature: _____ Address _____
 Examiner's name (print) _____ City _____
 State _____ Zip Code _____



NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine 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 and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, and screening for liver or kidney disorders, diabetes, and immune disorders.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV-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.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or 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 needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover 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. **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 as provided by law.**

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated. Because a trained person should deliver that information so that you can understand clearly what the test result means, please 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 for Reporting a Possible Positive Test Result _____

Address _____

In the event the test is positive and you are denied coverage because of that fact and you request the reasons for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

CONSENT

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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

Signature of Proposed Insured or Parent/Guardian

Address

USAA Number

Date

PLEASE SIGN AND RETURN THIS FORM

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Road San Antonio, Texas 78288
USAA LIFE INSURANCE COMPANY of NEW YORK Service Center 9800 Fredericksburg Road San Antonio, Texas 78288

37298-1103
LHV400ST

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 required) (only if marked)

Notary signature: _____ Notary Required
(Only if required) (only if marked)