

# VETERANS LIFE INSURANCE COMPANY

## SHORT FORM SUPPLEMENT TO APPLICATION

Every question must be asked the applicant by the Medical Examiner and the applicant's answers recorded in the Examiner's own handwriting and in ink. The applicant's signature must be made in the Examiner's presence. Examinations must be made in private.

Reference Number: _____							
Proposed Insured	First Name	Middle Name	Last Name	Date of Birth	Mo.	Day	Yr.

1. a. Name and address of your personal physician? (If none, state "None") \_\_\_\_\_

b. Date and reason last consulted? \_\_\_\_\_

c. What treatment was given or medication prescribed? \_\_\_\_\_

2. Are you now under observation, receiving treatment, or taking a prescribed medication? .....  Yes  No

3. Have you within the past 5 years:

Had an electrocardiogram, X-ray, or any other diagnostic test? .....  Yes  No

Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed? .....  Yes  No

4. Have you ever been declined, postponed, or rated up for insurance; or had a policy rated, canceled or limited, or its renewal or reinstatement refused? .....  Yes  No

Give full details to any "Yes" answer including diagnoses, dates, duration, medication(s) and full names and addresses of all attending physicians and medical facilities.

The foregoing are true and complete to the best of my knowledge and belief, and shall become part of my application to VETERANS LIFE INSURANCE COMPANY

DATE _____	SIGNATURE (PROPOSED INSURED): _____
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1. Height (in flat shoes): \_\_\_\_\_ Ft. \_\_\_\_\_ In.

2. Weight (Clothed): \_\_\_\_\_ Lbs.

3. Any weight change in the past year?

Gained? \_\_\_\_\_ lbs. \_\_\_\_\_

Lost? \_\_\_\_\_ lbs. \_\_\_\_\_

Cause? \_\_\_\_\_

4. Did you weigh and measure? .....  Yes  No

5. Blood pressure: (right arm while seated) (Two readings are recorded, none disregarded.) if systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 min. rest.

	1st.	2nd.	3rd.	4th.
Systolic				
Diastolic				
(5th. Phase)				

6. Pulse rate (at rest). Recorded for one full minute ..... Per/Min.

7. Urinalysis: Albumin \_\_\_\_\_ Sugar \_\_\_\_\_

Other: \_\_\_\_\_

8. Is specimen being sent? .....  Yes  No

Blood sample sent? .....  Yes  No

9. Special State Blood Work Consent Form required? .....  Yes  No

Secured? .....  Yes  No

10. Is the applicant a U.S. Citizen? .....  Yes  No

11. Was the paramedical conducted in the English language? .....  Yes  No

If no, complete the following:

a. Was an interpreter used? .....  Yes  No

b. What language was used? \_\_\_\_\_

c. What is the interpreter's relationship to the proposed insured? \_\_\_\_\_

This report was completed at:  PMI Office  Applicant's Home  Applicant's Office  Other (Specify \_\_\_\_\_)

in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_ at \_\_\_\_\_  A.M.  P.M.

Applicant Identified by:  Photo  Drivers License  Other \_\_\_\_\_

REMARKS	SIGNATURE OF EXAMINER OR TECHNICIAN	TITLE
	AFFIX PMI ADDRESS STAMP HERE	