

Part II of Application for Insurance to

Name of Proposed Insured _____

Date of Birth _____

- | | | |
|--|--------------------------|--------------------------|
| 1. a. Name and address of your personal physician? (if none, so state) | Yes | No |
| b. Date and reason last consulted? | | |
| 2. Have you ever been treated for, or told you had: | | |
| a. Disorder of eyes, ears, nose or throat?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headache; paralysis or stroke; mental or nervous disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. 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 murmur, heart attack or other disorder of the heart or blood vessels?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Ulcer, 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. Arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Deformity or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, lymph glands, cyst, tumor or cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Allergies; anemia or other disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever consulted a physician or had treatment with regard to the use of, or been convicted for the use or possession of: | | |
| a. Alcohol?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Narcotics, stimulants, sedatives or hallucinogenic drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever used tobacco in any form?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| what, when, how much per day? _____ | | |
| 5. Are you now under observation or taking treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any change in weight in the past year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other than above, have you within the past 5 years: | | |
| a. Had a checkup, consultation, illness, injury, surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been a patient in a hospital, clinic or other medical facility?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had electrocardiogram, X-ray, other diagnostic test?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Had any mental or physical disorder not listed above?..... | <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. In the last 3 years have you requested or received a pension or disability benefit for injury or sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you now pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, names and address of physicians and medical facilities.)

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

To the best of my knowledge and belief, the information given above is correctly recorded, complete and true.
(Any erasures or changes must be "initialed" by the Proposed Insured.)

Dated at _____ this _____ day of _____ 20_____

Signed in the presence of _____
(Medical Examiner)

(Signature of Proposed Insured)

Part III MEDICAL EXAMINER'S REPORT

Males Only :

12a. Height (in shoes) _____ ft. _____ in.	Weight (Clothed) _____ lbs.	Chest (Full Inspiration) _____ in.	Chest (Forced Expiration) _____ in.	Abdomen, at umbilicus _____ in.
b. Did you weigh?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you measure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Is appearance unhealthy or older than stated age?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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

13. Blood Pressure (Record All reading)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____
4th phase	_____	_____	_____
5th phase	_____	_____	_____

14. Pulse: _____

Rate	At Rest	After Exercise	3 Minutes Later
Irregularities per min.	_____	_____	_____

15. Heart: Is there any:

<input type="checkbox"/> Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Murmur(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Edema	<input type="checkbox"/> Yes <input type="checkbox"/> No

(describe below ---- if more than one, describe separately)

Location

Indicate:

- Constant
- Inconstant
- Transmitted
- Localized

- Systolic
- Diastolic

Apex by _____ X

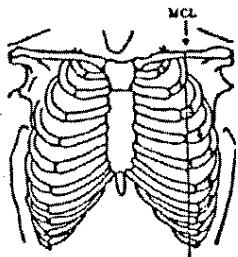
Murmur area by _____ O

Point of greatest intensity by _____ O

Transmission by →

- Soft (Gr. 1 -2)
- Mod. (Gr. 3 -4)
- Loud (Gr. 5 -6)

- After Exercise:
- Increased
- Absent
- Unchanged
- Decreased



16. Is there on examination any abnormality of the following (Check applicable items and give details)

a. Eyes, ears, nose, mouth, pharynx?.....	Yes	No
(if vision or hearing markedly impaired, indicate degree and correction)	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin (include 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	<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"/>

17. Are you aware of additional medical history?..... Yes No
(A confidential report may be sent to the Medical Director)

18. URINALYSIS Specific Gravity _____ Albumin _____ Sugar _____

Note: A specimen must be sent to the Home Office on all cases. Has a specimen been to Home Office Yes No

I have examined _____ in private at my office his residence

this _____ day of _____, 20____, and witnessed his (or her) signature herein:

Time of Examination : _____ A.M. _____ P.M.

Examiner's Signature M.D.



WEST COAST LIFE
INSURANCE COMPANY
P.O. Box 193892, San Francisco, CA 94119-3892
1-800-366-9378 / (415) 591-8200

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders or the presence of medications, drugs, nicotine and their metabolites. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood 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 of the 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 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 disease or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your HIV test result is negative, no routine notification will be sent to you. Because a trained person should deliver information regarding a positive test result so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you do not wish to know the results of the test, initial here: _____ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____ The results will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some Person other than yourself who is not a physician, print that person's name and address here:

_____.

The results will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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. This authorization is valid for six (6) months from the date signed.

Signature of Proposed Insured

Social Security No. and/or
Drivers License No. and State

Date

Witness

Date