

**MEDICAL EXAMINER'S REPORT**  
 In continuation, and forming a part, of the application for insurance to:  
**A—STATEMENTS TO THE EXAMINER**

THE WESTERN AND SOUTHERN LIFE INSURANCE CO.  
 WESTERN AND SOUTHERN LIFE ASSURANCE CO.

Proposed Insured _____ <small>First name Middle initial Last Name</small>			Month Day Year Birth Date: _____	
1. a. Name and address of Proposed Insured's personal physician? (If none, so state) _____ b. Date and reason last consulted? _____				
2. Has the Proposed Insured ever been treated for or ever had:			Yes No	
a. Disorder of eyes, ears, nose or throat? .....			<input type="checkbox"/> <input type="checkbox"/>	
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder? ..			<input type="checkbox"/> <input type="checkbox"/>	
c. Shortness of breath, persistent hoarseness or cough, blood spitting, 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. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, 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, reproductive organs or breasts? .....			<input type="checkbox"/> <input type="checkbox"/>	
g. Diabetes; thyroid or other endocrine disorders? .....			<input type="checkbox"/> <input type="checkbox"/>	
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? .....			<input type="checkbox"/> <input type="checkbox"/>	
i. Deformity, lameness or amputation? .....			<input type="checkbox"/> <input type="checkbox"/>	
j. Disorder of skin or 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. Other than above, has the Proposed Insured within the past 5 years:				
a. Had any mental or physical disorder? .....			<input type="checkbox"/> <input type="checkbox"/>	
b. Had a checkup, consultation, illness, injury, surgery? .....			<input type="checkbox"/> <input type="checkbox"/>	
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? .....			<input type="checkbox"/> <input type="checkbox"/>	
d. Had electrocardiogram, X-ray, other diagnostic test? .....			<input type="checkbox"/> <input type="checkbox"/>	
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? .....			<input type="checkbox"/> <input type="checkbox"/>	
4. During his or her entire lifetime, has the Proposed Insured used marijuana, LSD, barbiturates, cocaine, heroin or other narcotic, or other habit-forming drug, or been diagnosed, treated, or advised to be treated for alcoholism or drug use? <input type="checkbox"/> <input type="checkbox"/>				
5. During his or her entire lifetime, has the Proposed Insured been diagnosed by a health care professional as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex); or received treatment from a health care professional for AIDS or ARC? <input type="checkbox"/> <input type="checkbox"/>				
6. Has the Proposed Insured ever had military service deferment, rejection or discharge because of a physical or mental condition? <input type="checkbox"/> <input type="checkbox"/>				
7. Has the Proposed Insured ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? <input type="checkbox"/> <input type="checkbox"/>				
8. Any family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? .....			Yes No <input type="checkbox"/> <input type="checkbox"/>	
9.			Age if Living	Age at Death?
Father				
Mother				
Brothers and Sisters				
No. Living .....				
No. Dead .....				
10. Has the Proposed Insured used tobacco during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate type of tobacco product used, how much is used, or date when the use of any tobacco product ceased:				
11. Dates of last menstrual period?				
<b>DETAILS of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.</b> Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.				

I hereby declare, before affixing my signature hereto, I read the answers to the above questions, the answers as above written are as given by me in response to the questions; and, to the best of my knowledge and belief, all the answers are complete and true. I further declare no information has been concealed or withheld concerning past or present state of health and habits of the Proposed Insured

Signed at \_\_\_\_\_ City \_\_\_\_\_ mm/dd/yyyy Medical Examiner Sign as Witness \_\_\_\_\_ Signature of Proposed Insured (if under age 15, Parent or Guardian)

**MEDICAL EXAMINER: PLEASE COMPLETE VOUCHER**

- RULES FOR MEDICAL EXAMINER**
- Each item of information requested has a bearing on the insurability of the applicant and each question has been most carefully considered before its insertion in the examination form.
  - Ask each question as it is written and be sure that the import of each one is fully understood. Give full particulars on your report when the answer "Yes" or "No" does not cover the information sought.
  - Use black ink.
  - Do not use dashes or ditto marks for answers.
  - If related to Agent or applicant, do not examine.
  - Examinations should be made without Agent present.
  - Do not make "Test" or "Preliminary" examinations.

**MEDICAL EXAMINER'S VOUCHER**  
**WESTERN-SOUTHERN LIFE, CINCINNATI, OHIO 45202**

**TO BE FILLED IN BY MEDICAL EXAMINER**

NAME OF PROPOSED INSURED _____		DATE OF BIRTH _____
DATE OF EXAMINATION _____	NAME OF DISTRICT REQUESTING EXAMINATION _____	
NAME OF COMPANY EXAMINER OR PARAMEDICAL COMPANY (PLEASE TYPE OR PRINT TO ASSURE PROPER PAYMENT) _____ M.D.		
NUMBER AND STREET _____		
CITY AND STATE _____		ZIP CODE _____

**ORDER AND APPOINTMENT FOR MEDICAL EXAMINER**

**THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY**  
WESTERN-SOUTHERN LIFE ASSURANCE COMPANY

DATE

DISTRICT \_\_\_\_\_ ACCT. NO. \_\_\_\_\_ OFFICE CODE \_\_\_\_\_

ORDINARY NEW BUSINESS  MAO NEW BUSINESS  POLICY CHANGE  REVIVAL  POLICY NUMBER \_\_\_\_\_

To Medical Examiner \_\_\_\_\_ at \_\_\_\_\_

Name of Person To be Examined \_\_\_\_\_ Age \_\_\_\_\_

Reason for Examination \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Proposed Insured \_\_\_\_\_

**COMPLETE FOR LIFE ONLY**

Face Amt. or Selected Amt. Applied for \$ \_\_\_\_\_

Supp. Term \$ \_\_\_\_\_

Total Amt. Applied for \$ \_\_\_\_\_

Ord. In Force With W-S \$ \_\_\_\_\_

Total \$ \_\_\_\_\_

If total is \$100,000 or more for ages 55 and below or \$25,000 or more for ages 56 and above, check the proper for the age in section 18 below.

To be examined at:  
 Your Office  
 Residence  
 Place of Business

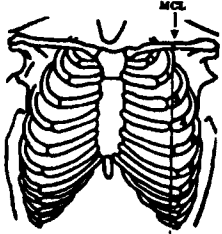
Date of Exam \_\_\_\_\_

Time  A.M.  P.M.

Applicant will phone  
 Phone Applicant

**DO NOT DETACH**

**B—STATEMENT OF THE EXAMINER'S FINDINGS**

1. a. Height (In Shoes) _____ ft. _____ in.	b. Weight (Clothed) _____ lbs.	c. Has weight changed in the past year? <input type="checkbox"/> Yes If "Yes" indicate _____ lbs. Lost <input type="checkbox"/> No _____ lbs. Gained	Details of "Yes" answers. (Identify Item.)
d. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No	e. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No	f. Is appearance unhealthy or older than stated age? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Blood Pressure (Record ALL readings.) Systolic _____ Diastolic-5th phase _____ <small>If initial blood pressure is elevated, repeat at end of examination.</small>			
3. a. Pulse rate _____ per min.	c. Irregularities in pulse At rest _____ per min. After exercise _____ per min.		
b. If pulse rate is 90 or over retake on held inspiration while bending forward. Pulse Rate _____ per min.			
4. Heart: Do you find any: Murmurs) At rest <input type="checkbox"/> Yes <input type="checkbox"/> No After exercise <input type="checkbox"/> Yes <input type="checkbox"/> No Location of murmur _____ indicate: Constant <input type="checkbox"/> Inconstant <input type="checkbox"/> Transmitted <input type="checkbox"/> Localized <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Soft (Gr. 1-2) <input type="checkbox"/> Mod. (Gr. 3-4) <input type="checkbox"/> Loud (Gr. 5-6) <input type="checkbox"/> After exercise: Increased <input type="checkbox"/> Absent <input type="checkbox"/> Unchanged <input type="checkbox"/> Decreased <input type="checkbox"/>			
Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No Edema <input type="checkbox"/> Yes <input type="checkbox"/> No			
Apex by X Murmur area by * Point of greatest intensity by O Transmission by †			
For comments and your impression:			
5. Is there on examination any abnormality of the following: <b>(Circle applicable items and give details.)</b>			YES NO
(a) Eyes, ears, nose, mouth, pharynx? _____ <small>(If vision or hearing markedly impaired, indicate degree and correction.)</small>			<input type="checkbox"/> <input type="checkbox"/>
(b) Skin (incl. 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"/>
6. (a) Are there any hernias? <input type="checkbox"/> Yes <input type="checkbox"/> No. (b) Any hemorrhoids? _____			<input type="checkbox"/> <input type="checkbox"/>
7. Are you aware of additional medical history? _____ <small>(A confidential report may be sent to the Medical Director.)</small>			<input type="checkbox"/> <input type="checkbox"/>

8. Urinalysis: Albumin _____ Sugar _____	9. SEND SPECIMEN TO LABORATORY ONLY IF: <input type="checkbox"/> Age 55 or less—Amount \$100,000 or over in force plus applied for <input type="checkbox"/> Age 56 or over—Amount \$25,000 or over in force plus applied for	<input type="checkbox"/> Abnormal contents on urinary examination, or systolic pressure 150 or higher <input type="checkbox"/> History or findings of a cardiac or renal disorder <input type="checkbox"/> Home Office request
Is specimen being sent to laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**SPECIAL ATTENTION**

REMARKS: \_\_\_\_\_

I certify that I made this examination at \_\_\_\_\_  A.M.  P.M. DATE \_\_\_\_\_

Examination made at  My office,  Proposed Insured's office,  Proposed Insured's home,  Other: \_\_\_\_\_

Examiner's signature: \_\_\_\_\_ Examiner's address: \_\_\_\_\_  
(No. & Street) (City) (State) (Zip Code)



# Western-Southern Life Assurance Company

## Paramedical Exam Checklist

400 Broadway

Cincinnati, Ohio 45202

1-866-244-5047

Please include the following forms with the lab package:

- Application** – Please verify applicant signature with Driver's License.  
(Any changes on the application must be initialed by the applicant.)  
**Texas Applications Only: Be sure to include a signed form 1144-IT-INT-R-TX.**

**Exam Package**

- Complete three (3) blood pressure readings.
- Clearly indicate physician name, complete address and phone number on exam form.
- Include Home Office specimen/blood profile, paramed exam, and HIV consent form.
- Additional Forms – (If provided in the application package):
  - Authorization for Release of Health Information Form (HIPAA Privacy)
  - Replacement Form
  - Sports Supplement
  - Aviation Supplement
  - Military Service Supplement
  - Authorization for Pre-Authorized Checking (PAC) Plan Form (Include voided check.)

**Comments:** *The forms should be fastened together via paper clip or rubber band.*

I have completed this order as thoroughly and accurately as possible and to the best of my professional abilities. I have submitted all of the above items as requested.

\_\_\_\_\_  
Examiner Signature

\_\_\_\_\_  
Date

Quality Control Review \_\_\_\_\_