WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK

100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

MEDICAL EXAMINERS REPORT

PART II OF APPLICATION To William Penn Life Insurance Company of New York

Examination to be made in private. Please read all questions to applicant. Answers to be recorded by the medical examiner in his own handwriting.

1. Proposed Insured's Name ______________
   A. Date of Birth (mo./day/yr.) ______________
   B. Height ______________
   C. Weight ______________
   D. Change in weight in past 12 months.
      Loss (lbs.)________ Gain (lbs.) ________
      Give reason ______________

E. Name of Personal Physician ______________
   Physician's Address ______________
   ____
   Physician's Telephone No. ______________
   Date and reason last consulted - if none, so state
   ____
   ____

	Yes	No	**Give full details if answer to Questions 2 through 11 is Yes. Details, Dates, Doctors' Names & Addresses**
2. Do you have any physical defect?	☐	☐	
3. Have you ever applied for or received disability benefits from any source?	☐	☐	
4. HAVE YOU:			
a. smoked cigarettes in the past 12 months?	☐	☐	
b. used tobacco in any other form in the past 12 months?	☐	☐	
5. HAVE YOU:			
a. used barbiturates, heroin, cocaine, marijuana, or any other illegal, restricted, or controlled substance except as prescribed by a physician? If Yes, when, how often?	☐	☐	
b. been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution?	☐	☐	
6. HAVE YOU:			
a. ever used alcoholic beverages? If Yes, how often and how many ounces?	☐	☐	
b. been advised to limit or cease the use of alcoholic beverages?	☐	☐	
c. been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?	☐	☐	
d. attended or joined any organization for alcohol or related problems?	☐	☐	
7. HAVE YOU EVER HAD:			
a. convulsions, paralysis, neuritis, nervous breakdown, dizziness, fainting spells, migraine headaches, nervous or mental disorders?	☐	☐	
b. high blood pressure, chest pain, palpitation, heart attack, disorder of heart or blood vessels?	☐	☐	
c. hemorrhage, asthma, tuberculosis, emphysema, disorder of respiratory system?	☐	☐	

TO MEDICAL EXAMINERS: This form must be completed by the Medical Examiner at the time of examination. Fees for such examinations are credited only upon receipt of this completed form at the Home Office.

SUBMITTED WITH THIS EXAMINATION: ☐ E.K.G. ☐ X-Ray ☐ Other ______________

Date____________, 20_____ . ______________, MD For Medical Examination of ______________ (Print Name in Full)

Please indicate fee (or attach invoice): ____________________

Doctor's Name and Address (Please Print or Use Rubber Stamp)

____

____

Applicant's Address ____________________

____

Agent's Name (Please Print) ____________________

Agency (Please Print) ____________________

	Yes	No	Details
d. shortness of breath, chronic hoarseness or cough, blood spitting? (past 10 years)	☐	☐	
e. chronic indigestion, ulcer, hernia, colitis, intestinal bleeding, disorder of stomach, gall bladder, liver, digestive or abdominal organs?	☐	☐	
f. kidney stone, diabetes, sugar, albumin, pus, or blood in urine, disorder of kidneys, bladder, genito-urinary organs?	☐	☐	
g. rheumatic fever, arthritis, gout, disorder of muscles, bones, joints or spine?	☐	☐	
h. impairment of vision or hearing or disease of eyes, ears, nose or throat?	☐	☐	
i. tumor, cancer, venereal disease, disorder of blood, skin, thyroid or other glands?	☐	☐	
j. treatment or observation in any hospital or institution? (past 5 years)	☐	☐	
k. x-rays, electrocardiograms, blood studies or other diagnostic tests other than an HIV or HTLV-III test (past 5 years). Give details.	☐	☐	
l. treatment or consultations with any physicians or practitioners, other than as stated above (past 5 years). Give details.	☐	☐	
8. Have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	
9. Have you in the past 5 years been advised to have or do you contemplate a surgical operation?	☐	☐	
10. Are you now pregnant? (If so, how many months)	☐	☐	

11. Provide family history

	Age, if Living	Age at Death	Cause of Death
Mother			
Father			
Brothers and Sisters			

The statements and answers are true to the best of my knowledge and belief and are made for the purpose of inducing the company to issue insurance on my life.

AUTHORIZATION. A photo copy of this authorization shall be as valid as the original, which shall be valid for 30 months. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records of knowledge of me or my health, to give William Penn Life Insurance Company of New York or its reinsurers any such information. This includes data related to drugs, alcoholism or mental illness. To expedite the collection of data, I authorize all such sources, except the Medical Information Bureau, to give the data to any agency employed by William Penn Life Insurance to collect and transmit such data. I am aware that I am entitled to receive a copy of this authorization form.

Signed at ____________________
City State

Dated ____________________

Proposed Insured ____________________

Witness ____________________
Examiner

MEDICAL EXAMINERS REPORT
PART III OF APPLICATION

Where indicated, give full details under number 9 or in a separate letter to the medical director.

1. How long have you known applicant?______________Yrs.
2. Is general appearance as to health and habits good?
   ☐ Yes ☐ No (If No, give details under No. 9)
3. a. Height in shoes_____ft. _____in.
   Did you measure? ☐ Yes ☐ No
   Weight (clothed) __________ lbs.
   Did you weigh? ☐ Yes ☐ No
   b. Any change in weight in past year?
   Gain ________ lbs. Loss ________ lbs.
   c. Reason for any change? ________________________
   Present weight maintained how long? ______________
   d. Chest: Inspiration_______ins. Expiration_______ins.
   Abdomen________ins.
4. Cardiovascular Examination:
   a. Blood Pressure: Systolic_________ Diastolic________
   If pressure is above 140 systolic or 90 diastolic, take two additional readings at least five minutes apart.

   b.

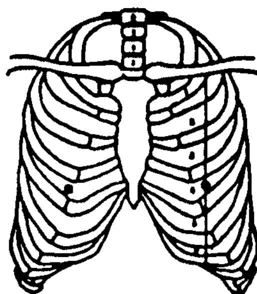
	Before Exercise	Immediately After	3 Minutes After
Pulse Rate			
Irregularities			

   c. Any dyspnea, pain or discomfort after exercise?
   ☐ Yes ☐ No
   d. Any sclerosis of peripheral vessels, clubbing, or cyanosis? ☐ Yes ☐ No
   e. Is the heart enlarged? ☐ Yes ☐ No
   (Locate apex by [X] on diagram.)
   f. Is there a murmur? ☐ Yes ☐ No
   (Examine heart in erect and recumbent positions.)

   Timing: Systolic ☐ Presystolic ☐ Diastolic ☐
   Intensity: Faint ☐ Moderate ☐ Loud ☐
   Grading: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

   Please comment on the presence or absence of thrills, or any undue accentuation of heart sounds, and on the effects of exercise, change of position, or phase of respiration.

   On diagram, locate:
   Apex by X
   Transmission by >
   Point of max. intensity by ○
   Area of murmur by ☐



   g. Based on the history and findings, what is your impression of the cardiac status? ________________

____
____
____
____
____
____

Please check appropriate column. Yes No

5. Do you find any evidence of past or present disease of?
   a. Brain or nervous system? (Test patellar and pupillary reflexes and observe gait.) ☐ ☐
   b. Lungs or respiratory organs? ☐ ☐
   c. Abdomen? (Describe scars, tenderness or masses. If a hernia is present, give size and reducibility.) ☐ ☐
   d. Genito-urinary system? ☐ ☐
   (Examine prostate if indicated by history.)
   e. Eyes, ears, nose or throat? ☐ ☐
   f. Bones, lymph glands, thyroid or skin? ☐ ☐
   g. Any other part of the body? ☐ ☐
6. a. Any varicosities, edema, amputation or deformity? ☐ ☐
   b. Artificial limb, brace or crutch used? ☐ ☐
7. Amount of Insurance applied for: $____________
8. Urinalysis - Repeat if Specific Gravity is below 1.012.

   Send a Specimen to the Home Office if:

   a. Amount in Question 7 above is:
   $100,000 and Over - Ages 0 - 60
   Any Amount - Over Age 60

   b. History of urinary disease or abnormal findings; ☐ ☐
   c. History or finding of hypertension; ☐ ☐

   Specific Gravity ____________ Albumin ☐ ☐
   Sugar ☐ ☐

   Are you sending a specimen to the Home Office? ☐ ☐
9. Details and Additional Remarks:______________________

____
____
____
____
____
____
____
____
____

To The Medical Examiner: Any erasures or alterations in this report should be initialed by you. Send this report, or any information which you prefer not to embody in this report, directly to the Medical Department of the Company.

Important: If the Examiner has any information which may adversely affect the risk, please indicate such information under item 9.

Mail when completed to: Medical Director, William Penn Life Insurance Company of New York, 100 Quentin Roosevelt Boulevard, PO Box 519, Garden City, New York 11530

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK

100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood 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 tests will be performed by a certified laboratory through a medically accepted procedure.

Meaning of Positive Test Result

A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing AIDS. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. It is possible to test negative when you have only recently been infected with HIV. You may wish to consider further independent testing.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined or that an increased premium may be charged.

For further information about AIDS, the meaning of HIV related test results and availability and location of HIV related counseling services, you may call the New York State Department of Health's toll free AIDS hotline: 1-800-541-AIDS, or any of the other New York State HIV counseling hotlines shown below.

Albany/Northeastern NY	(518) 457-7152	Syracuse Area	(315) 428-4736
Buffalo Area	(716) 847-4520	Bronx	(212) 716-3350
Nassau County	(516) 535-2004	Brooklyn	(718) 797-9110
New Rochelle and Mid-Hudson Valley	(914) 632-4133	Queens	(718) 262-9100
Rochester Area	(716) 432-8081	Harlem	(212) 694-0884
Suffolk County	(516) 348-2999	NYC Hotline	(718) 485-8111

COLLECT CALLS ACCEPTED
After hours Hotline: 1-800-872-2777
Monday thru Friday 4 p.m. to 8 p.m.
Saturday and Sunday 10 a.m. to 6 p.m.

You should also read the information regarding AIDS on page 3 of this form very carefully.
This information has been provided by the New York State Health Department.

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.

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 are entitled to that information if you so desire. Because a trained person should deliver that information 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 the test result and explain its meaning.

Name of physician for reporting a positive test result: ______________________________

Address ______________________________

If you wish the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

____

____

If you want the results sent directly to you, sign here: ______________________________

Positive results will be sent by registered mail for restricted delivery to the addressee.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. AIDS-Related Blood testing means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS. 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 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

____
Date Signed

AIDS Does not discriminate. It doesn't matter if you're

MALE	BLACK	RICH	GAY
FEMALE	WHITE	POOR	STRAIGHT

If you have sex with or share needles with an infected person, you can get AIDS. But we know how to prevent AIDS. Read the information below, and you'll know, too. Learn how to protect yourself from AIDS.

WHAT IS AIDS?

- AIDS stands for Acquired Immune Deficiency Syndrome, a disorder for which there is presently no cure.
- It is caused by a virus that many scientists call HIV (Human Immunodeficiency Virus). The virus can destroy the body's immune system, making it unable to fight off even small infections. The virus can also attack the nervous system, causing seizures, memory loss and mental disorders.
- The AIDS virus is carried in the blood, semen, vaginal fluid and other body secretions of an infected person. The virus must get into your bloodstream to cause AIDS.
- As many as 300,000 to 500,000 New Yorkers may already be infected with the AIDS virus. Most of these people don't know they're infected, because they have no symptoms.

HOW DO YOU GET AIDS?

- **By having sex with someone who has the AIDS virus.** During sex with an infected person, the virus contained in the blood, semen or other fluids can enter your body. It doesn't matter if you have sex with an infected person only once - you can still get AIDS!
- **By shooting drugs with a needle, syringe or "works" that has been used by someone who has the AIDS virus.** Invisible traces of infected blood from the last person who used the equipment could enter your body.
- A woman with the AIDS virus can give it to her unborn baby if she becomes pregnant. She is also more likely to develop AIDS if she becomes pregnant.

HOW DO YOU KNOW IF SOMEONE IS INFECTED?

- You can't tell if someone is infected with the AIDS virus just by looking at him or her.
- Most men and women infected with the virus don't know they are infected, because they have no signs or symptoms of illness. It can take several years before symptoms develop.
- Anyone who has ever shared a needle to shoot drugs could be infected. Researchers think that half of I.V. drug abusers are already infected!
- Anyone who ever had sex with a man or woman who shoots drugs could be infected.
- Anyone who has had many sexual partners could be infected - the more sexual partners, the greater the chances.
- Anyone who has had anal sex has an increased risk of being infected.
- Anyone who has a medical condition which required blood transfusions could be infected.

HOW CAN YOU STAY SAFE FROM AIDS?

- Don't have sex with anyone if you don't know his or her drug use and sexual history.
- Don't have sex with a large number of partners; this increases your risk of AIDS and other sexually transmissible diseases.
- Don't have anal sex. It can tear delicate tissues, letting infected semen or blood enter your bloodstream.
- Use a condom during sex to help keep the virus from getting into your body - unless you're **absolutely sure** your partner is not infected.
- Using a spermicide containing nonoxynol-9 along with condoms may provide further protection.
- NEVER shoot drugs.
- NEVER share a needle or other equipment to shoot drugs.
- Intravenous equipment can be sterilized by soaking it in alcohol for 10 minutes, or in one part bleach and 10 parts water for 10 minutes. Rinse thoroughly.

IS THERE A WAY TO FIND OUT IF A PERSON IS INFECTED?

- A blood test can tell if a person has been exposed to the virus. Free anonymous testing centers exist across the State. Anyone who wants a blood test can call 1-800-541-AIDS to learn more.
- Testing is recommended for anyone who has shared needles or engaged in high risk sexual activity.
- A woman who is thinking about becoming pregnant should consider being tested first if there's a chance she might have been exposed to the virus. If she is infected, she should consider postponing pregnancy to avoid giving birth to a baby infected with the virus.
- Counselors will help infected people learn how to avoid spreading the AIDS virus to others, and how to avoid further exposure to themselves.

FOR REFERRAL OR ASSISTANCE

Call the New York State AIDS Hotline toll-free: 1-800-541-AIDS or contact your nearest local AIDS program:

- Western NY AIDS Program, Inc.
(Buffalo-Niagara Falls)
(716) 847-AIDS
- AIDS Rochester
(716) 232-4430
- Central NY AIDS Task Force
(Syracuse area)
(315) 475-AIDS
- Southern Tier AIDS Program
(Binghamton area)
(607) 723-6520
- AIDS Council of Northeastern NY
(Albany-Adirondacks)
(518) 445-AIDS
- Mid-Hudson Valley AIDS Force
(includes Westchester and Rockland counties)
(914) 993-0607
- Long Island Association for AIDS Care, Inc.
(Nassau and Suffolk counties)
(516) 385-AIDS

IN THE NEW YORK CITY AREA:

- NYC AIDS Hotline
(718) 485-8111
- Haitian Coalition
(718) 855-0972
- Gay Men's Health Crisis
(212) 807-6655
- Hemophilia Foundation
(212) 682-5510
- Children and Youth AIDS Hotline
(212) 430-3333

Or write to: THE AIDS INSTITUTE, New York State Health Department, Empire State Plaza, Corning Tower - Room 2580, Albany, NY 12237

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____________________	____________________
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____________________	____________________
Address	Date Signed

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- AIDS Rochester
  (716) 232-4430
- Central NY AIDS Task Force
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- Southern Tier AIDS Program
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  (607) 723-6520
- AIDS Council of Northeastern NY
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  (518) 445-AIDS
- Mid-Hudson Valley AIDS Force
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  and Rockland counties)
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