Woodmen of the World/Omaha Woodmen Life Insurance Society

A Fraternal Benefit Society OMAHA, NEBRASKA

PART III - Paramedical Examination

Proposed Insured's Name for Life Insurance

First ____ MI ____ Last ____

Date of Birth ____ Social Security No. ____

Certificate No. ____ Amount Applied For ____

Field Representative's Name ____ Code ____

TO BE COMPLETED BY THE PROPOSED INSURED

1. Name and address of your personal physician? If none, check box ☐ ____
2. A. When did you last consult a physician? If not the personal physician, include name & address ____

   B. What symptoms or complaints did you have? ____

   C. What diagnosis was made and what treatment was prescribed? ____
3. Are you now taking any medication? Yes ☐ No ☐ If Yes, give name, dosage and reason for, if different from above information ____
4. Have you had any other illness or injury not mentioned above? Yes ☐ No ☐ If Yes, give details to include diagnosis, date, duration, treatment and name of attending physician. ____
5. In the past 12 months, have you used tobacco in any form, such as cigarettes, pipe, cigars, snuff, or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? Yes ☐ No ☐
   If Yes, date last used Mo. ____ Yr. ____ Indicate form(s) used: ____ If cigarettes, how many ppd? ____
   Have you ever used cigarettes in the past? Yes ☐ No ☐ If Yes, when did you quit? ____

The foregoing answers are true and complete to the best of my knowledge.

____ (Date) ____ (Signature of Proposed Insured)

TO BE COMPLETED BY THE EXAMINER

6. A. Height ____ B. Weight ____ C. # Lost Past Year ____
   D. Did you measure and weigh the person? ____ E. Weight Limit for your Scale ____
7. Blood Pressure: (If above 140/90 report additional readings five minutes apart)

   Systolic ____ ____ ____
   Diastolic ____ ____ ____
8. Pulse Rate: ____ Is it regular? ____ (If no, please describe) ____
9. If female, is applicant currently menstruating? Yes ☐ No ☐

➪ Age 13 and over, forward urine specimen to lab assigned to your paramedical company.

Affix paramed address or stamp Company name here & Phone no.

I understand that tests other than those specifically requested are not authorized, and will not be paid for by the Society. I have verified the identity of this applicant.

Signature of Examiner ____ Date ____ Daytime Phone No. ____

Printed Signature ____

Address ____ City ____ State ____ Zip ____

Form 5015 R-2/2001

Woodmen of the World/Omaha Woodmen Life Insurance Society

A Fraternal Benefit Society OMAHA, NEBRASKA

Part III
Physician's Report of Examination of Proposed Insured

Proposed Insured's Name for Life Insurance

First ____ MI ____ Last ____

Date of Birth ____ Social Security No. ____

Certificate No. ____ Amount Applied For ____

Field Representative's Name ____ Code ____

1. In the past 12 months, have you used tobacco in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco, OR smoking cessation products such as nicotine patches or nicorette gum? ☐ Yes ☐ No
   If yes, date last used? Mo. ________ Yr. ________
   Indicate form(s) used ________________ If cigarettes, how many ppd? ____
   Have you ever used cigarettes in the past? If so, when did you quit? ________
2. (a) Height ________ (d) Did you measure and weigh the person? ____
   (b) Weight ________ (e) Weight Limit for your scale ________
   (c) # Lost Past Year ________
3. Is medication taken for any medical condition? ☐ Yes ☐ No
   If so, state name of drug and condition requiring it. ________
4. If proposed insured is female; currently menstruating? ☐ Yes ☐ No
5. Blood Pressure: (If above 140/90 report additional readings five minutes apart.)

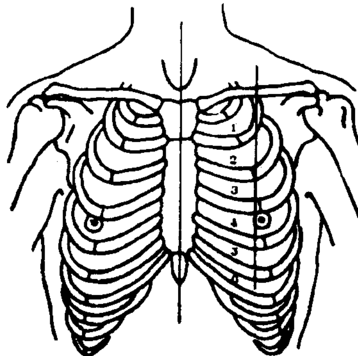
				HR. TAKEN
Systolic				
Diastolic (at disappearance of all sound)				

6. Pulse — Rate: ________ Is it regular? ________
7. Is there a murmur? ☐ Yes ☐ No Grade ________
8. If murmur is present X proper boxes.

Timing	Intensity	Quality
☐ Systolic	☐ Faint	☐ Soft
☐ Presystolic	☐ Moderate	☐ Blowing
☐ Diastolic	☐ Loud	☐ Rough

On exercise, does the murmur
☐ intensify?
☐ decrease?
☐ disappear?

Locate Apex by X
Area of murmur by outline ◌
Point of greatest intensity O
Transmitted by →



9. Diagnosis of heart condition:

EXAMINER:
Pay special attention to ________________.
AGE 13 AND OVER FORWARD URINE SPECIMEN (LIFE) TO LABORATORY ASSIGNED TO YOUR PARAMEDICAL COMPANY

10. Do you find evidence of past or present disease or abnormality or is there a history of the following:

	YES	NO
A. Brain or Nervous System-such as epilepsy, paralysis or mental illness to include treatment or counseling for depression or anxiety? . . . . A.	☐	☐
B. Respiratory System-such as asthma, emphysema, or tuberculosis to include disorders of the eyes, ears, nose or throat? . . . . B.	☐	☐
C. Circulatory System-such as high blood pressure, chest pain, heart attack, heart murmur, stroke, or phlebitis? . . . . C.	☐	☐
D. Digestive or Urinary Tract Systems-such as ulcer, colitis, hepatitis, nephritis, kidney stones, protein, blood or sugar in the urine to include diabetes and thyroid disorders? . . . . D.	☐	☐
E. Musculoskeletal System-such as arthritis, gout, back disorders or connective tissue disorders? . . . . E.	☐	☐
F. Reproductive System-such as prostate, testes, breast, ovaries or uterus disorders to include complications of pregnancy? . . . . F.	☐	☐
G. Immune System-such as AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any immunological disorder? . . . . G.	☐	☐
H. Has the proposed insured been diagnosed or treated for cancer or tumor of any kind? . . . . H.	☐	☐
I. Has the proposed insured had or been advised to have any surgical operation? . . . . I.	☐	☐
J. Has the proposed insured ever been treated or received counseling for alcohol use, alcoholism or drug addiction? . . . . J.	☐	☐
K. At any time in the past has the proposed insured had any other illness or injury not mentioned above? . . . . K.	☐	☐

DETAILS - Diagnosis, Date, Duration, Treatment, Name of attending physician.
ADDITIONAL SPACE AVAILABLE ON REVERSE SIDE

FORWARD DIRECT TO HOME OFFICE

I understand that tests other than those specifically requested are not authorized, and will not be paid for by the Society. I have verified the identity of the proposed insured.

________________ (Examiner Signature) ________________ (Date of Exam) IRS No. ________

Printed Signature ________________

Address ________________ (Street No.) (City) (State) (Zip)

Phone Number ________________ Include your statement or indicate your Fee $ ________

Form 6015 R-10/98

ADDITIONAL SPACE FOR DETAILS TO ANSWERS FROM REVERSE SIDE

X ______________________ X ______________________

EXAMINER SIGNATURE
WHEN DETAILS ARE GIVEN ABOVE

DATE

I HEREBY AUTHORIZE THE EXAMINING PHYSICIAN OR PARA-MEDIC TO EXAMINE ME FOR INSURANCE AND TO REVEAL TO WOODMEN OF THE WORLD/OMAHA WOODMEN LIFE INSURANCE SOCIETY ANY SIGNIFICANT MEDICAL HISTORY OR FINDINGS RELATIVE TO THIS EXAMINATION.

DATED ______________________

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FULL SIGNATURE OF THE PROPOSED INSURED