

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?.....
 - b. Dizziness, fainting, convulsions, headache; paralysis or stroke; mental or nervous disorder?.....
 - c. Bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?
 - d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?.....
 - e. Ulcer, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?.....
 - f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?.....
 - g. Diabetes; thyroid or other endocrine disorders?
 - h. Arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?.....
 - i. Deformity or amputation?
 - j. Disorder of skin, lymph glands, cyst, tumor or cancer?.....
 - k. Allergies; anemia or other disorder of the blood?.....
 - l. AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?.....
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?.....
 - b. Narcotics, stimulants, sedatives or hallucinogenic drugs?.....
4. Have you ever used tobacco in any form?.....
what, when, how much per day? _____
5. Are you now under observation or taking treatment?.....
6. Have you had any change in weight in the past year?.....
7. Other than above, have you within the past 5 years:
- a. Had a checkup, consultation, illness, injury, surgery?.....
 - b. Been a patient in a hospital, clinic or other medical facility?.....
 - c. Had electrocardiogram, X-ray, other diagnostic test?.....
 - d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?.....
 - e. Had any mental or physical disorder not listed above?.....
8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?.....
9. In the last 3 years have you requested or received a pension or disability benefit for injury or sickness?.....
10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?.....
11. Are you now pregnant?.....

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 |
| 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 | _____ | _____ | _____ |
| 4th phase | _____ | _____ | _____ |
| Diastolic | _____ | _____ | _____ |
| 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

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

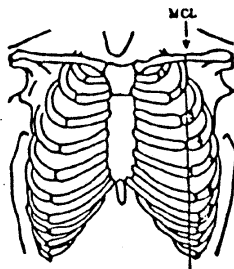
- After Exercise:
- Increased
- Absent
- Unchanged
- Decreased

Apex by **X**

Murmur area by **O**

Point of greatest intensity by **O**

Transmission by **→**



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

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