

Section 1 – Proposed Insured

1. Name of Proposed Insured _____
Sex: Male Female Date of birth ____/____/____
MM DD YYYY
2. Name and address of your usual physician or medical facility _____

Date and reason last consulted ____/____/____

Results, diagnosis, and/or treatment prescribed _____

Section 2 – Medical Questionnaire

1. In the past 10 years, have you had, been tested for, received treatment or counseling for, or been told by a medical professional that you have: *(If "Yes," circle the appropriate item in each question and provide details.)*
- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Dizziness, fainting, convulsions, epilepsy, seizures, paralysis, stroke, or severe headaches? . | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Depression, anxiety, stress, bipolar, mental, or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, bronchitis, emphysema, asthma, sleep apnea, pleurisy, or tuberculosis . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, elevated cholesterol, cardiac insufficiency, heart attack, or coronary artery disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heart murmur, heart valve disorder, edema, aneurysm, or disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, esophagus, intestines, spleen, pancreas, liver, or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, high blood sugar, or sugar in your urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Blood or protein in your urine, or any disorder of the kidneys, bladder, prostate, or urinary system? . | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any disease or disorder of the breasts or reproductive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thyroid, thymus, pituitary, adrenal, or lymph gland disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cancer, sarcoidosis, tumor, polyp, or any abnormal growth? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Multiple sclerosis or any disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Anemia, bleeding or clotting disorder, or any disorder of the blood (other than HIV-related)? . . . | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" Answers

Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.

| | Yes | No |
|--|--------------------------|--------------------------|
| 2. In the past 10 years, have you: | | |
| a. Been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or positive test results indicating the presence of the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. been medically treated, sought medical treatment, advised to seek medical treatment, or been hospitalized for alcohol or drug use, dependency, addiction or abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you used tobacco or nicotine products: | | |
| a. In the past 36 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other than above, in the past 5 years, have you had: | | |
| a. An examination or treatment by a doctor or medical practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Observation or treatment at a clinic, hospital, or other facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. An EKG, stress test, x-ray, blood test, or any other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A surgical operation or been advised to have a surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A change of weight, anorexia nervosa, or bulimia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. a. If female, are you currently pregnant? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had any complications with this or previous pregnancies? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. a. Do you have a family history of diabetes, cancer, stroke, kidney disease, high blood pressure, coronary artery disease, Huntington's chorea, alcoholism, drug abuse, or mental illness? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has any member of your immediate family (father, mother, brother, or sister) died before age 60 from cancer (breast, colon, intestinal, or prostate) or from a cardiovascular disease (heart attack, myocardial infarct, angina, cardiac insufficiency, cerebral thrombosis, or coronary artery disease)? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you ever received disability benefits from any source? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Details of "Yes" Answers
Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.

I declare that the statements and answers contained in this Part 2 of Application are full, complete, and true to the best of my knowledge and belief and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 of Application shall be part of my application for insurance and will form part of the policy contract.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Examiner (Witness)

Signature of Proposed Insured

Medical Examiner's Report

This section is to be completed by all examiners.

This section is to be completed by physician only.

All Proposed Insureds must be weighed and measured.

1. a. Height _____ft. _____in.
b. Weight _____lbs.
Weight change in past 12 months? Yes No
Lost _____ lbs. Gained _____ lbs.
Reason? _____

2. Blood Pressure:
Systolic 1) _____ 2) _____ 3) _____
Diastolic 1) _____ 2) _____ 3) _____
*Take 2 readings at least 5 minutes apart.
If blood pressure is over 140/90, take a third reading.*

3. Pulse _____
Rhythm _____
Irregularities? _____
If pulse is over 90, repeat in 5-10 minutes.

4. Urinalysis:
*Please indicate test results in the space provided.
This section is to be completed on all examinations.*
Albumin _____
Glucose _____
Blood _____
Please forward urine sample to LabOne for urinalysis.

5. Does the Proposed Insured appear older than the stated age? Yes No

6. Is there any evidence of alcohol, drug, or nicotine addiction? Yes No

7. Any evidence of past or present disease of:
- a. The brain or nervous system? *(Test reflexes and coordination)* Yes No
 - b. Head or neck? *(Include ears, eyes, and mouth)* Yes No
 - c. Endocrine system, breasts, or glands? Yes No
 - d. Chest and lungs? *(Examine on bare chest with expiratory cough)* Yes No
 - e. Heart and blood vessels? Yes No
 - f. Abdomen? *(Include liver, spleen, abnormal masses, tenderness, and surgical scars)* Yes No
 - g. Genitourinary system? *(Include prostate)* Yes No
 - h. Musculoskeletal system? *(Include spine/joint deformities)* Yes No
 - i. Skin *(Include xanthomas, nevi, etc.)* or lymph nodes? Yes No

8. Is there:
- a. Evident arteriosclerosis? Yes No
 - b. Cardiac hypertrophy? Yes No
 - c. Cyanosis, dyspnea, or edema? Yes No
 - d. Cardiovascular impairment? Yes No
 - e. Any hernias or varicosities? Yes No
 - f. A heart murmur? *(Complete heart chart)* Yes No

9. Heart Chart
- Murmur
- Location: Apical Aortic
 Mitral Pulmonic
- Timing: Systolic Diastolic Pre-systolic
- Intensity: Soft Moderate Loud
- Grade: I II III IV V VI
- Is murmur constant? Yes No
- Transmitted? Yes No
- If transmitted, indicate to where _____
- Effect of exercise: Unchanged Decreased
 Increased Disappears
- Your impression of murmur _____

