

**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 5 years, have you 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"/>
o. Alcoholism, drug addiction, or excessive use of alcohol or drugs? . . . . .	<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
<b>2. In the past 10 years, have you:</b>		
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"/>
<b>3. Have you used tobacco or nicotine products:</b>		
a. In the past 36 months? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 12 months? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Other than above, in the past 5 years, have you had:</b>		
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"/>
<b>5. a. If female, are you currently pregnant? . . . . .</b>		
	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Have you ever had any complications with this or previous pregnancies? . . . . .</b>		
	<input type="checkbox"/>	<input type="checkbox"/>
<b>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? . . . . .</b>		
	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Has any member of your immediate family (father, mother, brother, or sister) died <b>before age 60</b> 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)? . . . . .</b>		
	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. Have you ever received disability benefits from any source? . . . . .</b>		
	<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.

### 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

## This section is to be completed by physician only.

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 \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

