

Medical Questionnaire

Instructions:

- Be sure to use the current and correct state specific form.
- **Fees for Incomplete Exams will be charged back.**
- Pose each question exactly as printed.
- Check each 'YES' / 'NO' box - All questions must be answered.
- **Client must be weighed on a scale and measured.**
- Be sure to sign and date the form.
- Include the Agency name and number on all Lab ID slips.
- Paramedicals complete Pgs 1 & 2 and Pg 3 questions 1-11.
- Physicians complete the form in full.
- Non-Med Requirement: Pgs 1 & 2 completed by Agent.
- Deliver or mail the completed form.

1. Full Name of Proposed Insured _____

2. Address _____

3. Social Security No. _____ 4. Date of birth _____ 5. Place of birth _____

6. Telephone No. _____ 7. E-mail _____

8. Height _____ Weight _____ lbs. Change in last year _____ lbs. Reason? _____

If any question is answered 'Yes', give dates, details, results & include physician's name, address and phone number in Remarks on page 2.

9. a. To the best of your knowledge, is your health impaired in any way? Yes No
 b. Are you taking any medications currently? If so, what and why? Yes No
 c. Have you ever applied for or received disability compensation from any source? Yes No
10. a. Within the past 10 years have you made the decision, or have you been advised by a physician or other medical professional, to reduce alcohol intake or have you attended meetings of an alcohol self-help group or Alcoholics Anonymous? Yes No
 b. Except as prescribed by a physician, have you ever used narcotic drugs, amphetamines, cocaine, barbiturates, tranquilizers, hallucinogens or marijuana? Yes No
 c. Do you now use nicotine products in any form (including cigarettes, cigars, chewing tobacco, smokeless tobacco, pipe, "the patch", snuff or nicotine gum) or have you used nicotine products in any form within the last 24 months? Yes No
11. To the best of your knowledge, within the past 10 years, have you been diagnosed with or received professional treatment or advice for:
 a. Chest pain, heart murmur, rheumatic fever or irregular heart beat? Yes No
 b. Habitual cough, asthma, emphysema, sleep apnea, or shortness of breath? Yes No
 c. Ulcer, jaundice or chronic indigestion? Yes No
 d. Stroke, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, fainting or memory loss? Yes No
12. To the best of your knowledge, within the past 10 years, have you received professional treatment or advice for disease or disorder of:
 a. Heart, veins, arteries, blood, blood pressure, anemia or cholesterol? Yes No
 b. Lungs or respiratory tract? Yes No
 c. Esophagus, stomach, intestines, rectum, liver or gall bladder? Yes No
 d. Kidney, bladder, prostate, genito-urinary organs, pelvic organs or breast? Yes No
 e. Eyes, ears, nose, throat or sinuses? Yes No
 f. Brain, nervous system or headaches? Yes No
 g. Spine, bones, muscles, joints, skin or glands? Yes No
13. To the best of your knowledge, within the past 10 years, have you been advised by a physician or other medical professional that you had:
 a. Cancer, polyp or other tumor? Yes No
 b. Gout, arthritis, back pain or back disorder? Yes No
 c. High blood sugar or diabetes? Yes No
 d. Albumin, sugar, protein or blood in the urine? Yes No
 e. Renal colic or kidney stone? Yes No
 f. Anxiety, depression, neurosis, psychosis, psychological problem or condition? Yes No
14. Within the past 10 years has a physician or other medical professional diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
15. Have you had x-rays, electrocardiograms or other diagnostic tests (except for an HIV test) within the past 5 years? If so, where? Yes No
16. Have you within the past 5 years been in or do you plan to enter or have you been advised by a person licensed in a medical profession, practicing within the scope of his or her license, to enter a hospital for observation, operation or treatment? Yes No
17. Do you have pending, or do you intend to make within the next 30 days, an appointment with any physician or other medical professional? Why? Yes No

Medical Questionnaire (Continued)

18. Have you consulted any physicians or other medical professionals other than your personal physician within the past 5 years? Yes No

19. To the best of your knowledge, has any member of your family been diagnosed with or treated by a member of the medical profession for diabetes, heart disease, cancer, Huntington's Disease or polycystic kidney disease? Yes No

| 20. Family History | Age if alive | State of Health | Age at death | Cause of death |
|--------------------|--------------|-----------------|--------------|----------------|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ | _____ |

| 21. Name and Address of Personal Physician (If none, so state) | Date last seen | Reason consulted & outcome |
|--|----------------|----------------------------|
| | | |

22. Remarks (Provide dates, details, results & include physician's name, address and phone number to any questions so requested. An additional sheet of paper may be attached, if necessary.)

| Question Number | Additional Information |
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Signatures

I have read the answers to the foregoing questions. They are correctly recorded and they are complete and true to the best of my knowledge and belief. They shall be used by the Company in any action it takes. This application will be attached to and made a part of the policy.

(Please sign name in full)

Signature of Proposed Insured _____ Date _____

Proposed Insured (Print) _____

Signature of Witness _____ Date _____

Witness (Print) _____

Medical Questionnaire (Continued)

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_____ (Proposed Insured) is being examined at the request of _____ (Agent)

Explain 'Yes' answers to questions 2-6 in Remarks.

1. Did the Proposed Insured fully understand the questions? (If 'No', provide details in Remarks.) Yes No
2. Do you know the Proposed Insured? Yes No
3. Are you related to the Proposed Insured? Yes No
4. Does the Proposed Insured appear **unhealthy**? Yes No
5. Are you the Proposed Insured's personal physician? Yes No
6. Do you have any knowledge of the Proposed Insured's habits, environment or other factors which might aid in the appraisal of the Proposed Insured? Yes No

Remarks

7. Was Proposed Insured weighed and measured? Yes No
 - a. Height in shoes: _____ ft. _____ in.
 - b. Weight in clothes: _____ lbs.
8. Girth: (for Males only)
Chest _____ in. Abdomen at umbilicus _____ in.
9. Blood Pressure and Pulse
 - a. Three blood pressure readings:
____ / ____ , ____ / ____ , ____ / ____
Note: If blood pressure is 140/90 or higher, a recheck is required on another day. You may schedule for this now. Please note date of recheck.
 - b. Pulse rate: _____
 - c. Pulse irregularities: _____

10. Specimens forwarded to (Name of Laboratory)

_____ on (date) _____

11. What requirements were completed?

- Blood Profile Urinalysis Resting EKG
 Stress Test Chest X-Ray

Questions 12 & 13 to be completed by Physician only

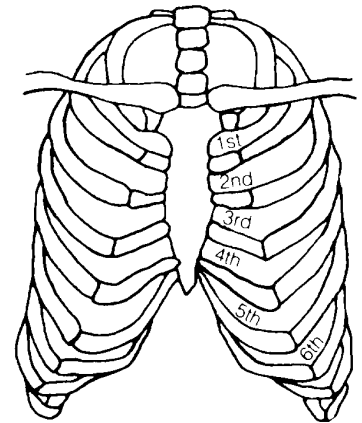
12. Do you find any abnormality of:
 - a. Sight or hearing Yes No
 - b. Eyes, ears, nose, or throat Yes No
 - c. Lungs or chest Yes No
 - d. Abdominal organs or digestive tract Yes No
 - e. Nervous system including reflexes Yes No
 - f. Thyroid, endocrine system, or skin Yes No
 - g. Muscular or skeletal systems Yes No
13. Heart - Do you find any:
 - a. Enlargement Yes No
 - b. Murmur(s) Yes No
 - c. Dyspnea Yes No
 - d. Edema Yes No

If murmur is present describe and illustrate

Systolic _____ Localized _____
 Diastolic _____ Soft I-II _____
 Presystolic _____ Moderate III-IV _____
 Constant _____ Loud V-VI _____
 Transmitted _____

Indicate:

- Apex by **X**
 Murmur area by **○**
 Heard loudest by **↑**
 Transmission by **↓**



- Effect of exercise increase decrease none
 Effect of inspiration increase decrease none
 Effect of expiration increase decrease none
 Impression:

Name, Address & Telephone No. of Examining Facility

Location/Date & Time of Exam

If exam not arranged by paramed company, Tax ID/EIN # required & please submit a separate "itemized" bill.

Physician/Paramedical (Print)

Signature of Physician/Paramedical