National Life Group®

☐ **National Life Insurance Company®**
☐ **Life Insurance Company of the Southwest®**

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 1-10.
- Non-Med Requirement: Pgs 1 & 2 completed by Agent.
- Email the completed form to NBRequirementImages@NationalLife.com

This Medical Questionnaire is submitted in conjunction with an application to a Company of the National Life Group.

1. Name *(first, middle, last)* _____

2a. Date of Birth _____ 2b. Place of Birth _____

3a. Height _____ Weight _____ 3b. Have you gained or lost weight during the last 12 months? *(If 'Yes', provide details in Remarks.)* ☐ Yes ☐ No

If any question is answered 'Yes', provide details, including diagnosis, date(s), results & physician's name, address and phone number, in Remarks.

4. Are you currently taking, or have you taken within the last 12 months, any prescription medications or over the counter drugs, including aspirin and/or herbal supplements? *(If 'Yes', provide name of medication and reason/diagnosis.)* ☐ Yes ☐ No
5. Within the last 5 years have you used any product containing tobacco or nicotine, including but not limited to cigarettes, e-cigarettes, vape pens, cigars, pipes, chewing tobacco, snuff, nicotine gum and/or nicotine patch? *(If 'Yes', provide type of product used, frequency, and date of last use in Remarks.)* ☐ Yes ☐ No
6. In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, been self-admitted to a drug or alcohol treatment facility, or been a member of a support group such as NA or AA? ☐ Yes ☐ No
7. Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation? ☐ Yes ☐ No
8. In the past 10 years have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
   a. Any disorder or abnormal condition of the heart, including irregular heartbeat, murmur, rheumatic fever, coronary artery disease, heart attack, chest pain, angina, high blood pressure, or high cholesterol? ☐ Yes ☐ No
   b. Any disorder or abnormal condition of the circulatory or vascular system, including aneurysm, transient ischemic attack, stroke, carotid artery or arterial disease? ☐ Yes ☐ No
   c. Any disorder or abnormal condition of the lungs or respiratory system, including sleep apnea, shortness of breath, asthma, bronchitis, emphysema, chronic obstructive pulmonary disease, tuberculosis, or allergies? ☐ Yes ☐ No
   d. Any digestive system disorder, including ulcer, chronic indigestion, hepatitis, cirrhosis, jaundice, or abnormal condition of the liver, stomach, intestine or pancreas, esophagus, gallbladder, or colon? ☐ Yes ☐ No
   e. Any disorder or abnormal condition of the brain or nervous system, including seizures/epilepsy, tremors, falls or imbalance, fainting, dizzy spells, headaches or migraines, loss of consciousness, confusion or memory loss, paralysis, numbness, or any condition which causes limited motion? ☐ Yes ☐ No
   f. Any disorder or abnormal condition of the eyes, ears, nose, throat, or sinuses? ☐ Yes ☐ No
   g. Any disorder or abnormal condition of the endocrine system, including thyroid, pituitary, adrenal or other gland? ☐ Yes ☐ No
   h. Any disorder or abnormal condition of the spine, hip, knee, shoulder, back, joints, bones, muscles, arthritis, rheumatism or gout? ☐ Yes ☐ No
   i. Any disorder or abnormal condition of the urinary system, including bladder, kidney, or urinary abnormalities such as protein, sugar or blood in urine? ☐ Yes ☐ No
   j. Any disorder or abnormal condition of the genital system, including prostate, testicles, pelvic organs, ovaries, cervix, uterus, or breast? ☐ Yes ☐ No
   k. Any disorder or abnormal condition of the skin, including psoriasis, eczema, non-healing wounds, melanoma, nevi or moles? ☐ Yes ☐ No
   l. Any depression, anxiety, bipolar, schizophrenia, Attention Deficit Disorder (ADD), autism, Down Syndrome or any other developmental or psychological condition including Alzheimer's, dementia, or Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No
   m. Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   n. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
   o. Any cancer, tumor, polyp, lump, nodule, cyst, lymphoma or any disorder of the lymph nodes? ☐ Yes ☐ No
   p. Diabetes, high blood sugar, pre-diabetes, impaired glucose tolerance, impaired fasting glucose, insulin deficiency, hyperglycemia, or diabetes associated with pregnancy? ☐ Yes ☐ No
   q. Amputation due to disease or other medical condition? ☐ Yes ☐ No

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NLIC: One National Life Drive, Montpelier, VT 05604 | **LSW:** 15455 Dallas Parkway, Suite 800, Addison, TX 75001

r. Ataxia, transverse myelitis, myasthenia gravis, autoimmune disorder such as lupus, blindness, or post-polio syndrome? ☐ Yes ☐ No

s. Parkinson's disease, muscular dystrophy, Huntington's chorea, motor neuron disease, Lou Gehrig's Disease (ALS), or multiple sclerosis? ☐ Yes ☐ No

9. Within the past 5 years have you:

a. Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization, mammograms, ultrasounds, biopsy, or any other medical tests and/or procedures, except those related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No

b. Been admitted to a hospital, seen in an Emergency Department or been advised by a member of the medical profession to enter a hospital for observation, operation or treatment of any kind? ☐ Yes ☐ No

10. Do you have any pending appointments with any health care provider or medical facility? *(If yes, provide date, physician/facility name and address, and reason for visit.)* ☐ Yes ☐ No

11. Has a biological parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease, Lou Gehrig's Disease (ALS), or polycystic kidney disease? ☐ Yes ☐ No

12. Do you currently:

a. Use or require the use of a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift? ☐ Yes ☐ No

b. Need help, assistance or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? ☐ Yes ☐ No

c. Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation? ☐ Yes ☐ No

13. Family History

	Age if alive	Age at death	Cause of death
Father			
Mother			

14. Name and address of medical care facility and/or health care provider *(or indicate if none)*

Name and address of medical care facility and/or health care provider *(or indicate if none)*	Date last seen	Reason consulted & outcome

15. Remarks *(Provide the details to any questions answered 'Yes'.)*

Question Number	Additional Information

Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.

Signatures

Caution: If your answers on this application are misstated or untrue, and the answers were made with the intent to deceive the insurer, or the answers materially affected its acceptance of risk or hazard, the insurer may have the right to deny benefits, including the denial of your accelerated death benefit coverage.

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.

Signature of Proposed Insured *(Please sign name in full)* _____ Date _____

Proposed Insured *(Print)* _____

Signature of Witness *(Please sign name in full)* _____ Date _____

Witness *(Print)* _____

Medical Questionnaire *(Continued)*

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Note: MD exams are no longer required.

_____ *(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 _____
   b. Weight in clothes _____
8. Blood Pressure and Pulse
   a. Three blood pressure readings
   ____ / ____ , ____ / ____ , ____ / ____
   b. Pulse rate _____ c. Pulse irregularities _____
9. Specimens forwarded to *(Name of Laboratory)*
   _____
   on *(date)* _____
10. What requirements were completed?
    ☐ Blood Profile ☐ Urinalysis ☐ Resting EKG
    ☐ Senior Assessment

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

_____