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 1-11.
- Physicians complete the form in full.
- Non-Med Requirement: Pgs 1 & 2 completed by Agent.
- Deliver or mail the completed form.

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

National Life Insurance Company
Home / Administrative Office: One National Life Drive, Montpelier, VT 05604

Life Insurance Company of the Southwest
Administrative Office: One National Life Drive, Montpelier, VT 05604
Home Office: 1300 West Mockingbird Lane, Dallas, TX 75247-4921

1. Full Name of Proposed Insured _____

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

3. 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.

4. a. Have you ever been diagnosed or treated for any physical disability or impairment? ☐ 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

5. 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 support group? ☐ 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

6. 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

7. 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

8. 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

9. 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), AIDS Related Complex (ARC), or AIDS related conditions? ☐ Yes ☐ No

10. Have you had x-rays, electrocardiograms or other diagnostic tests, other than for AIDS or HIV testing purposes, within the past 5 years? If so, where? ☐ Yes ☐ No

11. 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

Medical Questionnaire *(Continued)*

12. 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

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

14. 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

15. Family History

	Age if alive	State of Health	Age at death	Cause of death
Father				
Mother				
Siblings				
Siblings				

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

17. Remarks *(Provide dates, details, results & include physician's name, address and phone number to any questions so requested.)*

Question Number	Additional Information

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.

(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

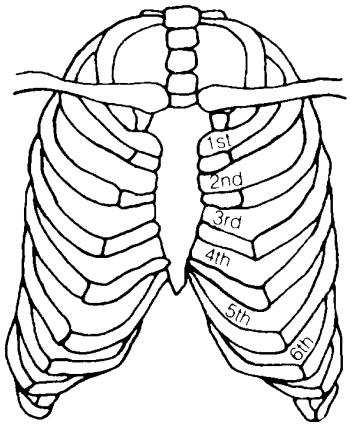
Questions 12 & 13 to be completed by Physician only

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 O
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