National Life Group[®]

□ National Life Insurance Company[®] □ Life Insurance Company of the Southwest[®]

Medical Questionnaire

Instructions:

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- 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.

	ame (first, middle, last)			
2a. D	ate of Birth	2b. Place of Birth		
3a. H	eight Weight	t 3b. Have you gained or lost weight during the last 12 months? (If 'Yes', provide details in Remarks.)	🗌 Yes	s 🗌 No
lf any	question is answere	d 'Yes', provide details, including diagnosis, date(s), results & physician's name, address and phone number	r, in Rei	marks.
4. A in	e you currently taking cluding aspirin and/o	g, or have you taken within the last 12 months, any prescription medications or over the counter drugs, r herbal supplements? (If 'Yes', provide name of medication and reason/diagnosis.)	Yes	s 🗌 No
e	cigarettes, vape pen	have you used any product containing tobacco or nicotine, including but not limited to cigarettes, s, cigars, pipes, chewing tobacco, snuff, nicotine gum and/or nicotine patch? (If 'Yes', provide type cy, and date of last use in Remarks.)	Yes	s 🗌 No
b	/ a physician to disco	ive you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised intinue or reduce alcohol or drug intake, used drugs not prescribed by a physician, been self-admitted atment facility, or been a member of a support group such as NA or AA?	🗌 Yes	s 🗌 No
7. W	ithin the past 5 years	have you worked less than full time, received or applied for disability or worker's compensation?	🗌 Yes	s 🗌 No
	the past 10 years ha the medical professi	ive you ever been diagnosed, treated, tested positive for, or been given medical advice by a member on for:		
	disease, heart attac	ormal condition of the heart, including irregular heartbeat, murmur, rheumatic fever, coronary artery k, chest pain, angina, high blood pressure, or high cholesterol?	Yes	s 🗌 No
	stroke, carotid arter	ormal condition of the circulatory or vascular system, including aneurysm, transient ischemic attack, y or arterial disease?	🗌 Yes	s 🗌 No
	bronchitis, emphyse	ormal condition of the lungs or respiratory system, including sleep apnea, shortness of breath, asthma, ma, chronic obstructive pulmonary disease, tuberculosis, or allergies?	🗌 Yes	s 🗌 No
	the liver, stomach, in	m disorder, including ulcer, chronic indigestion, hepatitis, cirrhosis, jaundice, or abnormal condition of ntestine or pancreas, esophagus, gallbladder, or colon?	🗌 Yes	s 🗌 No
e.	Any disorder or abn fainting, dizzy spells any condition which	ormal condition of the brain or nervous system, including seizures/epilepsy, tremors, falls or imbalance, s, headaches or migraines, loss of consciousness, confusion or memory loss, paralysis, numbness, or causes limited motion?	Yes	s 🗌 No
f.		ormal condition of the eyes, ears, nose, throat, or sinuses?		
g.	Any disorder or abn	ormal condition of the endocrine system, including thyroid, pituitary, adrenal or other gland?	🗌 Yes	s 🗌 No
h.	Any disorder or abn gout?	ormal condition of the spine, hip, knee, shoulder, back, joints, bones, muscles, arthritis, rheumatism or	Yes	s 🗌 No
i.	Any disorder or abn sugar or blood in uri	ormal condition of the urinary system, including bladder, kidney, or urinary abnormalities such as protein, ine?	Yes	s 🗌 No
j.	Any disorder or abn or breast?	ormal condition of the genital system, including prostate, testicles, pelvic organs, ovaries, cervix, uterus,	Yes	s 🗌 No
	•	ormal condition of the skin, including psoriasis, eczema, non-healing wounds, melanoma, nevi or moles?	🗌 Yes	s 🗌 No
	developmental or pa	xiety, bipolar, schizophrenia, Attention Deficit Disorder (ADD), autism, Down Syndrome or any other sychological condition including Alzheimer's, dementia, or Post Traumatic Stress Disorder (PTSD)?	Yes	s 🗌 No
			Yes	s 🗌 No
	exposure to or beer	•		s 🗌 No
0.	Any cancer, tumor,	polyp, lump, nodule, cyst, lymphoma or any disorder of the lymph nodes?	🗌 Yes	s 🗌 No
	hyperglycemia, or d	d sugar, pre-diabetes, impaired glucose tolerance, impaired fasting glucose, insulin deficiency, liabetes associated with pregnancy?	Yes	s 🗌 No
q.	Amputation due to o	disease or other medical condition?	🗌 Yes	s 🗌 No
1443(04	21) National L Southwes	ife Group® is a trade name of National Life Insurance Company (NLIC), Montpelier, VT, Life Insurance Company of the t (LSW), Addison, TX and their affiliates. Each company of National Life Group is solely responsible for its own financial		Page 1 of 3 No. 51194

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

Me	dical Questionnaire (Cont	tinued)						
	r. Ataxia, transverse myelitis s. Parkinson's disease, muse	cular dystrophy, l	Huntington's che	orea, motor neuron	disease, Lou Gehrig's Dise			No
0	multiple sclerosis?							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						🗌 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
	1. 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?							🗌 No
12.	Do you currently:							
	a. Use or require the use of any mechanical or medical devices such as: 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?							
	c. Need help, assistance or s	•	•	•	aundry, shopping or meal p	preparation?		No No
13.	Family History Age if ali	ve Age	e at death	Cause of death				
	Father Mother							
14.	Name and address of medica care provider (or indicate if no		d/or health	Date last seen	Reason	consulted & outcome		
15.	Remarks (Provide the details to	o any questions an	swered 'Yes'.)					
	Question Number	Additional Inf	ormation					
Er	aud Warning							
Ar	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.							
	gnatures							
	ave read the answers to the	forogoing guesti	no Thou are	orrootly rooorded a	nd they are complete and	true to the heat of row	المعايدة	ام ممط

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)

Instructions:

- Be sure to use the current and correct state specific form.
- Client must be weighed on a scale and measured.
- Fees for Incomplete Exams will be charged back.
- Include the Agency name and number on all Lab ID slips.

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	 9. Specimens forwarded to (Name of Laboratory) on (date)		
Name, Address & Telephone No. of Examining Facility	If exam not arranged by paramed company, Tax ID/EIN # required & please submit a separate "itemized" bill.		
	Physician/Paramedical (Print)		
Location/Date & Time of Exam	Signature of Physician/Paramedical		