

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. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for exposure to or been diagnosed with HIV or AIDS? 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

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
