Reset Form

Medical Exam For Age 70 and Under

This form is part of the Application for Life Insurance for the Proposed Life Insured.
Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

PROPOSED LIFE INSURED

1. a) Name _____ b) Date of Birth ____ ____ ____

First Middle Last month day year

c) Gender ☐ Male ☐ Female

SMOKING STATUS

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?

☐ Yes ☐ No If 'Yes', provide details below.

Product:		Frequency:	Current	Past	Date Last Used (month day year)
Cigarettes	_____	pack(s)/day	☐	☐	
Cigars	_____	x /day	☐	☐	
Other: _____	_____	x /day	☐	☐	

FAMILY QUESTIONS

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes ☐ No

4. Please provide the following details.

Living			Deceased		
	Age	**Give Details of Present State of Health**		**Age**	**Cause of Death**
Father			Father		
Mother			Mother		
Brothers and Sisters			Brothers and Sisters		

5. a) Name and Address of Personal or Attending Physician

First Middle Last

Street No. & Name Suite No. City State Zip code

b) Telephone No. _____

c) Date last consulted Reason for consultation Diagnosis/Result of visit

month day year

d) List any medications (prescription or nonprescription) you are taking currently

HEALTH QUESTIONS - Please complete Details for 'Yes' answers on page 3.

6. **Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have:**

a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No

b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease? ☐ Yes ☐ No

c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? ☐ Yes ☐ No

d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis? ☐ Yes ☐ No

e) Any nervous, mental or emotional disorder, or received counseling for anxiety, depression, stress, or any other emotional condition? ☐ Yes ☐ No

f) Alzheimer's disease, dementia, memory loss or organic brain syndrome? ☐ Yes ☐ No

g) Multiple sclerosis (MS), muscular dystrophy, ALS (Lou Gehrig's disease), Parkinson's disease or tremors? ☐ Yes ☐ No

h) Injuries due to falls or imbalance? ☐ Yes ☐ No

i) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, fractures, or any other bone, joint or muscle disorder? ☐ Yes ☐ No

j) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? ☐ Yes ☐ No

k) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines? ☐ Yes ☐ No

l) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? ☐ Yes ☐ No

m) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? ☐ Yes ☐ No

n) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine? ☐ Yes ☐ No

o) Cancer, leukemia, lymphoma, malignant melanoma or tumors of any kind, malignant or benign? ☐ Yes ☐ No

p) Any other health impairment or medically treated condition? ☐ Yes ☐ No

7. **Within the last 10 years have you had:**

a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? ☐ Yes ☐ No

b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), whether conducted on an in-patient or out-patient basis? ☐ Yes ☐ No

8. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

9. Do you:

a) have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed? ☐ Yes ☐ No

b) consume alcoholic beverages?

☐ Never ☐ Currently ☐ In the past

Complete if **Currently** was selected in 9 b)

Type of beverage	Frequency	Quantity

Complete if **In the past** was selected in 9 b)

Date Stopped (month / year) _____

Reason Stopped _____

10. **Within the last 10 years have you:**

a) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counseling or participated in a support group? ☐ Yes ☐ No

b) used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? ☐ Yes ☐ No

c) used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions? ☐ Yes ☐ No

HEALTH QUESTIONS - continued

Question No.	Date Month	Day	Year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

1. The Company to obtain an investigative consumer report on me.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, or any other similar person or organization to give The Company and its reinsurers information about me or any minor child who is to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

I further authorize The Company to disclose such information and any information developed during its evaluation of this application to: (a) its reinsurers; (b) other insurance companies as designated by me; (c) me; (d) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (e) any medical professional designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

SIGNATURES

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief.
I hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at City Country This Day of Year

Signature of Proposed Life Insured

X

I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Life Insured.

Signature of Examiner as Witness Print Name of Examiner

X

Name of Financial Representative -

EXAMINER'S REPORT - Complete for all medical examinations.

Section 1

11. a) Height _____
Did you measure? ☐ Yes ☐ No
b) Weight _____
Did you weigh? ☐ Yes ☐ No
c) Any weight change in the past 12 months? ☐ Yes ☐ No
If 'Yes', amount _____ ☐ Loss ☐ Gain
Reason _____

12. Blood Pressure Readings.

	Standing	Sitting	Lying
Systolic			
Diastolic			

13. Pulse _____ ☐ Regular ☐ Irregular
Type of irregularity _____
If extra systoles, No. per min. _____

14. Describe general appearance (older than stated age, alert?)

15. Did anyone accompany the Proposed Life Insured during the examination? ☐ Yes ☐ No
If 'Yes', please provide details
Name of the person who came _____ Relationship to Proposed Life Insured _____
Why present _____

16. Did the Proposed Life Insured understand and answer all the questions asked in connection with this exam? ☐ Yes ☐ No
If 'No', please provide details _____

17. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? ☐ Yes ☐ No
If 'Yes', please provide details _____

Section 2

18. On examination is/are there any:

a) Extra or abnormal heart sounds? ☐ Yes ☐ No
b) Murmurs? ☐ Yes ☐ No
c) Cardiomegaly or cardiac enlargement? ☐ Yes ☐ No
d) Inadequate circulation anywhere? ☐ Yes ☐ No
(e.g. shortness of breath, edema, stasis dermatitis, PVD)
If 'Yes', provide details below.

Please complete the following heart chart if there are any YES answers to question 18, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or if there is a history of hypertension or heart disease.

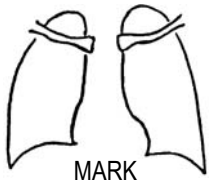
Murmur If more than one, describe in Details below.

☐ None ☐ Systolic ☐ Diastolic | Grade I II III IV V VI | ☐ Loud ☐ Harsh ☐ Rough ☐ Soft ☐ Blowing

Signs of Failure

Shortness of breath? ☐ Yes ☐ No
Cyanosis? ☐ Yes ☐ No
Engorgement of neck veins? ☐ Yes ☐ No
Swelling of ankles? ☐ Yes ☐ No
Rales at lung bases? ☐ Yes ☐ No

Location
Area of Murmur by XXXX
Transmission by .....→



SECTION 2 - continued

Complete Details below for Yes answers to questions 19-20.

19. On examination, is there any abnormality of:
    a) Respiratory system? ☐ Yes ☐ No
    b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)? ☐ Yes ☐ No
    c) Eyes, ears, nose, mouth, pharynx, head and neck (incl. hearing, vision, optic fundi, speech)? ☐ Yes ☐ No
    d) Skin, lymph nodes, peripheral arteries or veins? ☐ Yes ☐ No
    e) Nervous system (incl. reflexes, weakness, gait, paralysis, tremors)? ☐ Yes ☐ No
    f) Genitourinary system (incl. prostate, rectum (only if male), external genitalia, breasts)? ☐ Yes ☐ No
    g) Endocrine systems (including thyroid)? ☐ Yes ☐ No
    h) Musculoskeletal system (incl. spine, joints, amputation, deformity)? ☐ Yes ☐ No
20. Have you examined the Proposed Life Insured in the past year? ☐ Yes ☐ No
    Is the Proposed Life Insured your private patient? ☐ Yes ☐ No

If 'Yes', please provide details of any medical history which is pertinent to the mortality risk and not already disclosed.

Question No.	Date Month Day Year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

EXAMINER'S CERTIFICATION AND SIGNATURE

How did you identify the Proposed Life Insured? ☐ Driver's License (with photo) ☐ Other photo ID - give details _____

☐ Passport _____ Country

Examination location ☐ Examiner's Office ☐ Other - give details _____

Indicate requirements completed ☐ Blood ☐ EKG ☐ CXR ☐ Urine ☐ TST

Date provided to Distributors _____ month day year

Indicate any requirements not completed and reason

I hereby certify that I have personally examined the Proposed Life Insured and have correctly and fully reported my findings.

Signed at City Country This Day of Year

Name of Examiner

Signature of Examiner

X

Address - City, Country, Mailing Code

Telephone No.

Examination completed on (date and time)

month day year Time