



**B.** Other than as stated in 4A, has any immediate family member of the Proposed Insured (parents, siblings or children), been diagnosed with heart disease prior to age 50, Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease, porphyria, cardiomyopathy, sickle cell anemia, Huntington's disease, aneurysm, or cancer? .....  yes  no  
*(Please provide details including type, age of onset, and relationship(s) to Proposed Insured.)*

**Details:** \_\_\_\_\_

**C.** Is there a family history of mental illness, suicide, or substance abuse in your immediate family (parents and siblings only)? .....  yes  no  
*(Please provide details including diagnosis and relationship(s) to Proposed Insured.)*

**Details:** \_\_\_\_\_

**5. Personal Health History**

**A.** Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) high cholesterol? .....  yes  no  
 Date of diagnosis \_\_\_\_\_ most recent level \_\_\_\_\_ treatment \_\_\_\_\_

2) high blood pressure? .....  yes  no  
 Date of diagnosis \_\_\_\_\_ most recent reading \_\_\_\_\_ treatment \_\_\_\_\_

3) diabetes? .....  yes  no  
 Date of diagnosis \_\_\_\_\_ most recent HgbA1c \_\_\_\_\_ treatment \_\_\_\_\_

**B.** Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? .....  yes  no

2) blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? .....  yes  no

3) cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? .....  yes  no

4) pituitary, thyroid, adrenal, or disease or disorder of any other glands? .....  yes  no

5) anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? (excluding HIV tests) .....  yes  no

6) colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? .....  yes  no

7) disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? .....  yes  no

8) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? .....  yes  no

9) seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? .....  yes  no

10) attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? .....  yes  no

11) anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? .....  yes  no

12) arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? .....  yes  no

13) glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? .....  yes  no

*(For any yes answers, provide details such as: date of diagnosis, date of last treatment; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)*

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**C. Other than previously stated,** has the Proposed Insured taken any medications, had treatment or therapy or been under medical observation within the **past 12 months**? .....  yes  no  
*(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



- D.** Has the Proposed Insured in the **past 12 months** had but NOT consulted a medical professional for:
- 1) fainting spells, dizziness, numbness, headaches, convulsions or paralysis? .....  yes  no
  - 2) pain or discomfort in the chest, shortness of breath, hoarseness, unexplained cough or coughing up of blood?...  yes  no
  - 3) disorders of the stomach, intestines or rectum, rectal bleeding or blood in the urine? .....  yes  no
  - 4) sores that have not healed or changes in the appearance of a mole? .....  yes  no
  - 5) anxiety, depression, loss of memory, disorientation or confusion? .....  yes  no
- (For any yes answers, list condition such as: date of first occurrence; symptoms; and how treated.)*

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- E.** Within the **past 5 years**, has the Proposed Insured used alcoholic beverages? .....  yes  no  
 If yes, Average number of drinks per week \_\_\_\_\_ Maximum number of drinks per day \_\_\_\_\_  
 Type (Beer, Wine, Liquor) \_\_\_\_\_ Date of last use \_\_\_\_\_

- F.** Has the Proposed Insured **ever**:
- 1) used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? .....  yes  no
  - 2) used marijuana (prescribed or otherwise) in any form? .....  yes  no
  - 3) used a controlled substance or prescription drug in a manner other than prescribed by a physician? .....  yes  no
  - 4) sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances? .....  yes  no
- If answered "Yes" to F1 through F4, please provide details below.

Type of drug(s) and/or alcohol \_\_\_\_\_ Date last used \_\_\_\_\_  
 Frequency of use:  Daily  Weekly  Monthly Amount typically used: \_\_\_\_\_  
 Name(s) of doctor/facility \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Treatment Dates \_\_\_\_\_  
 Support group(s) \_\_\_\_\_  
 Was treatment or support group attendance court ordered? .....  yes  no  
 Details of any drug or alcohol related arrests \_\_\_\_\_

- G.** Has the Proposed Insured **ever** been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? .....  yes  no  
*(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor.)*

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- H.** Other than previously stated, in the **past 5 years**, has the Proposed Insured:
- 1) been hospitalized, consulted a member of the medical profession or had any illness, injury or surgery? .....  yes  no
  - 2) been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was NOT completed (except for those tests related to the Human Immunodeficiency Virus), or does the proposed insured have any test results pending? .....  yes  no
  - 3) undergone any self-administered laboratory test other than those for pregnancy or Human Immunodeficiency Virus (HIV)? .....  yes  no
  - 4) made a claim for or received benefits, compensation, payment or pension for any injury, sickness, disability, or impaired condition? .....  yes  no

*(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)*

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



I. Has the Proposed Insured had any emergency room, emergency clinic, walk-in clinic, or free clinic visits during the **past 5 years**? .....  yes  no  
*(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

J. Has the Proposed Insured **ever** been advised to or chosen to enter a nursing home, hospice, or assisted living facility? .....  yes  no  
*(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

K. Within the **last 2 years** has the Proposed Insured:

- 1) experienced fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing, or shortness of breath? .....  yes  no
- 2) received home health care services, physical therapy or rehabilitation therapy? .....  yes  no
- 3) required the use of a cane, walker, wheelchair, other assistive device, or resided in an assisted living facility?....  yes  no
- 4) required assistance or supervision with or had any limitations in performing any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? .....  yes  no
- 5) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside of the home or preparing meals? .....  yes  no

*(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

L. Has the Proposed Insured been treated for or been diagnosed with, or does the Proposed Insured have, any other medical, physical, or psychological condition **NOT** disclosed above? .....  yes  no  
*(If yes, list condition and details such as: date of first occurrence; symptoms; and how treated.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**EXAMINATION  
Physical Measurements**

**1. Proposed Insured**

A. \_\_\_\_\_  
 First Name MI Last Name

B. Build: Measured Height (*in shoes 1 in heel or less*) \_\_\_\_\_ ft \_\_\_\_\_ in Measured Weight (*clothed*) \_\_\_\_\_ lbs  
 1) Did you measure the Proposed Insured's height.....  yes  no  
 2) Did you weigh Proposed Insured? .....  yes  no  
 3) If unable to obtain measured height or weight, please provide reason \_\_\_\_\_

C. Blood Pressure and Pulse  
 Blood Pressure: Three readings required, spaced at least five minutes apart.  
 Pulse: Only required once if heart rate between 50-100 bpm, otherwise obtain three measurements.  
 Select cuff size:  Standard BP cuff  Large BP cuff

	1st Reading	2nd Reading	3rd Reading
Systolic BP			
Diastolic BP			
Pulse Rate			
Irregularities Per Min.			

D. Have any of the following been completed in conjunction with this exam?  Blood  Urine  EKG

E. Examiner observations and remarks  
 1) Is appearance unhealthy or older than stated age?.....  yes  no  
 2) Are there any obvious physical abnormalities?.....  yes  no  
 3) Did anyone assist the Proposed Insured in answering any questions?.....  yes  no  
 4) Does Proposed Insured use any device to aid in locomotion (e.g. cane, walker, wheelchair)? .....  yes  no  
 5) Does Proposed Insured use any other assistive device not previously disclosed (e.g. oxygen, prosthetic limb)? ...  yes  no  
 6) Does Proposed Insured seem confused, disoriented or otherwise impaired?.....  yes  no  
 7) Does Proposed Insured have any speech difficulties or use a voice prosthesis?.....  yes  no  
 8) Was this appointment conducted in a language other than English? (if yes, indicate language and who provided interpretation or translation services) .....  yes  no  
 9) Do you have any pertinent information or observation not previously disclosed? .....  yes  no

**Details** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Are you related to the Proposed Insured by blood or marriage or do you have a business or professional relationship with the Proposed Insured? (*If yes, explain*) .....  yes  no  
 \_\_\_\_\_  
 \_\_\_\_\_

**Report By Examining Medical Doctor**

**Instructions to doctor:**

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart  
 a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? .....  yes  no  
 b. Is heart enlarged? (*If yes, describe*) .....  yes  no  
 c. Is murmur present? (*If yes, complete question d*) .....  yes  no  
 d. Murmur is:  
 Constant Transmitted to where? \_\_\_\_\_  
 Inconstant Localized at:  Apex  Base  Elsewhere  
 Systolic (*Give details*) \_\_\_\_\_  
 Diastolic Murmur grade: (*Please circle*) 1/6 2/6 3/6 4/6 5/6 6/6  
 After valsalva, murmur is:  
 Unchanged  Decreased  Increased  Absent

Your impression \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**Report by Examining Medical Doctor (continued)**

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction)*....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

b) Endocrine system *(including thyroid)?*.....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

c) Nervous system *(including reflexes, gait, paralysis)?* .....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

d) Respiratory system?.....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

e) Abdomen *(including scars)?* .....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

f) Genito-urinary system?.....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

g) Skin *(including scars)*, lymph nodes, blood vessels?.....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* .....  yes  no

**Details** \_\_\_\_\_  
\_\_\_\_\_

**Signature**

**Paramedical Examiner/Medical Doctor Signature**

I certify that this exam was conducted the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_, at \_\_\_\_\_  am  pm

Location of Exam \_\_\_\_\_ **Paramed: Use company stamp below.**

Examiner Address \_\_\_\_\_

Examiner Phone # \_\_\_\_\_

Examiner Name \_\_\_\_\_

Examiner Signature **X**

*(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion)*

