Reset Form

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

GA # _____

Application Part 2
Health History

☐ Paramedical ☐ Medical

File # _____

1. **Proposed Insured:** *(Print Full Name)*	2. **Date of Birth:** Month Day Year	3. **Social Security #**

4. **Name/Address/Phone of primary care physician:**

Name: _____ Address: _____

Phone: (_____) _____ City/St/Zip: _____

Date and reason for last visit: _____

Give complete details of all yes answers to questions 5 - 8, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

5. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**	**Yes**	**No**
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☐
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☐
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☐
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☐
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☐
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☐
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☐
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☐
i. Cancer, tumor, polyp or cyst?	☐	☐
j. Any physical deformity or amputation?	☐	☐
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐	☐
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	☐	☐

6.	**Yes**	**No**
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	☐	☐
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☐

7. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**	**Yes**	**No**
a. Consulted, been examined or been treated by any physician or practitioner?	☐	☐
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	☐	☐
c. Had observation or treatment at a clinic, hospital or other medical facility?	☐	☐
d. Had or been advised to have a surgical procedure?	☐	☐
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☐
f. Had any injury requiring treatment?	☐	☐

Details:

* D T 2 2 4 *

File # _____

8.

	Yes	No
a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	☐	☐
b. Has your weight changed by more than 15 pounds in the past year?	☐	☐
c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐	☐
d. Are you now pregnant?	☐	☐

9. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** ☐ Yes ☐ No *If yes, list all and indicate why.*

10. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters # _____				

11. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** ☐ Yes ☐ No *If yes, indicate type, frequency and date last used.* _____

12. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☐ Yes ☐ No *If no, provide complete details.*

13. Do you participate in regular weekly exercise? ☐ Yes ☐ No
14. Do you participate in athletics *(Team or Individual)?* ☐ Yes ☐ No
15. Have you ever used any tobacco products? ☐ Yes ☐ No
16. Do you get regular examinations by your health care provider? ☐ Yes ☐ No
17. Do you get regular annual dental checkups? ☐ Yes ☐ No
18. Do you clean your house or do yard work? ☐ Yes ☐ No
19. Do you have a pet? ☐ Yes ☐ No
20. Are you a member of a social group or volunteer for charity work? ☐ Yes ☐ No

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on _____, _____

Signature of Vendor Representative or Physician

Signature of Proposed Insured

Print name of Proposed Insured

To The Examiner:

File # _____

(Not a Part of the Application for Insurance)

If completed in person, the questions on Pages 1 and 2 must be completed and signed before you.
You must ask the Proposed Insured each question and record the answer.

Questions 21 & 22 For Medical Examiner Use only

Name of Proposed Insured:

_____

Social Security #: _____

Height: _____ Ft. In. Did you measure? _____

Weight: _____ Lbs. Did you weigh? _____

Males Only

A. Chest Expanded _____ In.

B. Chest Contracted _____ In.

C. Abdomen _____ In.

Blood Pressure Obtain 3 Readings

Systolic _____ mm Diastolic _____ mm
Systolic _____ mm Diastolic _____ mm
Systolic _____ mm Diastolic _____ mm

Pulse Rate _____ per minute.

Irregularities ☐ Yes ☐ No Give number per minute _____

Yes No

☐ ☐ Are you in any way related to the Proposed Insured or Insurance Producer? *If yes, give details.*

_____

Yes No

☐ ☐ Was the examination conducted in a language other than English? *If yes, indicate language used and, if applicable, name & relationship of person acting as interpreter.*

_____

_____

Name of Insurance Producer requesting examination:

_____

21. **ANY EVIDENCE OF PAST OR PRESENT MEDICAL CONDITION OR DISORDER OF THE:**

Yes No

☐ ☐ a. Brain, nervous system?
☐ ☐ b. Ears, nose, eyes, throat, teeth or gums?
☐ ☐ c. Thyroid or lymph glands?
☐ ☐ d. Heart, blood vessels? *(If yes, complete Question No. 22.)*
☐ ☐ e. Lungs?
☐ ☐ f. Stomach or abdominal organs?
☐ ☐ g. Genito-urinary system?
☐ ☐ h. Skin or extremities?

22. **TO BE COMPLETED IF QUESTION 21d IS ANSWERED YES.**

Yes No

☐ ☐ a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?
☐ ☐ b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?
☐ ☐ c. Are there gallops (S3 or S4)?
☐ ☐ d. Are there ejection sound(s) or systolic click(s)?
☐ ☐ e. Is/Are there murmur(s) present?

If yes, fully describe under "Details". For murmurs, include timing (systolic or diastolic), intensity (grd. 1-6), location, transmission, radiation.

Details:

INSTRUCTIONS Complete all questions above.

No examiner has any authority to issue a certificate of health or to declare the Proposed Insured acceptable for insurance. Under our rules, only the Company's underwriting department has authority to determine the insurability of the applicants for insurance.

Mail the specimen for laboratory analysis to the laboratory listed on the collection kit or as instructed by your paramedical company.

EXAMINATION WAS MADE AT:

☐ My Office
☐ Residence of Proposed Insured
☐ Place of Business of Proposed Insured.
☐ Other: _____

At _____ AM/PM on _____ , _____

Others present *(indicate None or list name/relationship):*

_____

SIGNATURE OF EXAMINER _____

Print Examiner Name: _____

Company Branch #: _____

Tax Identification Number: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone No.: _____

If mailing, send to: Transamerica Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, IA 52499
AWD Fax #: 1-800-814-2205