UNIFI Companies

Part II – Medical

CHECK ALL COMPANIES THAT APPLY:

☐ **Acacia Life Insurance Company**
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Department)

☐ **Ameritas Life Insurance Corp.**
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335

☐ **The Union Central Life Insurance Company**
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218

Proposed Insured: _____ Birth Date: _____
First Name Middle Name Last Name Month Day Year

Health Questions. Please complete Details for "Yes" answers.

1. a. Height: _____ b. Weight: _____
   c. Have you lost 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
   d. Have you gained 10 lbs. or more in the past 12 months? ☐ Yes ☐ No
2. Have you ever been medically treated for or had any known indication of:
   a. Disorder of eyes, ears, nose, or throat? ☐ Yes ☐ No
   b. Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, paralysis, or stroke? ☐ Yes ☐ No
   c. Shortness of breath, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e. Jaundice, intestinal bleeding; ulcer, hernia, colitis, hepatitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? ☐ Yes ☐ No
   f. Sugar, albumin, blood or pus in urine; sexually transmitted disease; stone or other disorder of kidney or bladder? ☐ Yes ☐ No
   g. Diabetes, thyroid, or other endocrine disorders? ☐ Yes ☐ No
   h. Disorder of breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   i. Neuritis, arthritis, rheumatism, gout, or disorder of or injury to the bones, muscles, nerves, knees, wrists or other joints? ☐ Yes ☐ No
   j. Disorder of skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   k. Allergies, anemia or other disorder of the blood? ☐ Yes ☐ No
   l. Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m. Anxiety, depression, stress or other mental, nervous, psychiatric or emotional disorder? ☐ Yes ☐ No
   n. Chronic fatigue, fibromyalgia, or Epstein-Barr virus? ☐ Yes ☐ No
   o. C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   p. Any mental or physical disorder not listed above? ☐ Yes ☐ No
3. Have you ever consulted a chiropractor? ☐ Yes ☐ No
4. Are you currently pregnant? ☐ Yes ☐ No
5. Other than noted above, have you within the past five years:
   a. Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had an electrocardiogram, X-ray, or other diagnostic test? ☐ Yes ☐ No
   b. Been advised by a licensed medical professional to have any diagnostic test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
6. Within the past ten years, have you ever:
   a. Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b. Received medical treatment from a licensed medical practitioner or been convicted of or entered a plea of no contest regarding for the use of alcohol, cocaine, marijuana, narcotics or any other drug? ☐ Yes ☐ No
   c. Consumed alcoholic beverages? If yes, specify extent. ☐ Yes ☐ No
7. Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
8. Have any of your immediate family members (parents, brothers and sisters), died of or been diagnosed as having; coronary artery disease, diabetes, cancer, stroke or kidney disease, prior to age 60? ☐ Yes ☐ No

	Age if Living	Cause of Death	Age at Death
Father:			
Mother:			
Brothers & Sisters			

9. a. Name and address of personal or attending physician:
   b. Telephone: _____
   c. Date last consulted: _____
   Reason and any medication/treatment given:
   d. List any medications *(prescription or nonprescription)* you are taking currently:

For each "Yes" answer, give details. (Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional sheet if needed.)

I, the undersigned, declare that the answers to the foregoing questions relate to the proposed insured, are complete and true as written to the best of my knowledge and belief, are correctly recorded, are made for the purpose of obtaining the insurance and any supplemental benefit applied for and shall form a part of any contract issued by the Companies on this application and the initial application (UN 2550, et al.)

Dated at: _____
City State Month Day Year

Witness: _____
(Must be Examiner)

Signature of Proposed Insured: _____

Signature of Parent or Guardian: _____
If Proposed Insured is under age 18

MEDICAL EXAMINER'S REPORT

1. a. Height (in shoes) ___ ft. ___ in. | Weight (clothed) _____ lbs. | Chest (full inspiration) _____ in. | Chest (forced Expiration) _____ in. | Abdomen at Umbilicus _____ in.

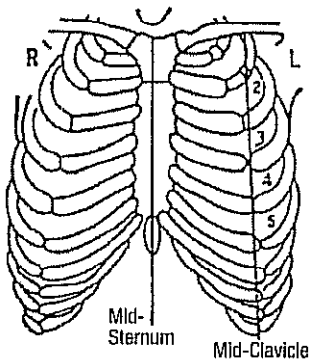
   b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

2. Blood Pressure (record ALL readings):

	At Rest	After Exercise	3 Minutes Later
Systolic			
4th phase			
Diastolic			
5th phase			
3. Pulse: Rate			
Irregularities			

4. Heart: Is there any:
   Enlargement . . . ☐ Yes ☐ No Dyspnea . . . . ☐ Yes ☐ No
   Murmer(s) . . . . ☐ Yes ☐ No Edema . . . . . ☐ Yes ☐ No
   (Describe below. If more than one, describe separately.)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐



Indicate:
Apex by X
Murmer area by ◌
Point of greatest interest by ○
Transmission by →
Please record your comments or impressions.

5. Is there on examination any abnormality of the following:
   (Circle applicable items and give details.)
   a. Eyes, ears, nose, mouth, pharynx? . . . . . ☐ Yes ☐ No
   (If vision or hearing markedly impaired, indicate degree and correction.)
   b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ☐ Yes ☐ No
   c. Nervous system (include reflexes, gait, paralysis)? . . . . . ☐ Yes ☐ No
   d. Respiratory system? . . . . . ☐ Yes ☐ No
   e. Abdomen (include scars)? . . . . . ☐ Yes ☐ No
   f. Genitourinary system? . . . . . ☐ Yes ☐ No
   g. Endocrine system (include thyroid and breasts)? . . . . . ☐ Yes ☐ No
   h. Musculoskeletal system (include spine, joints, amputations, deformities)? ☐ Yes ☐ No
6. Are there any hernias? . . . . . ☐ Yes ☐ No
7. Are you aware of additional medical history? . . . . . ☐ Yes ☐ No
   (A confidential report may be sent to the Medical Director)
8. Is appearance unhealthy or older than stated age? . . . . . ☐ Yes ☐ No
9. Has the applicant used any form of tobacco within the past 24 months? ☐ Yes ☐ No
   Indicate: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew or "Smokeless"

10. How long and how well have you known the applicant?

    _____

    _____

11. Urinalysis

Albumin	Sugar	Blood

Have you mailed the urine specimen? ☐ Yes ☐ No

Specimen must be mailed in UNIFI mailer if any of the following factors apply:

1. Age 60 or over.
2. Amount of life insurance is $100,000 or more.
3. Current blood pressure reading over 140/90.
4. Albumin, sugar or occult blood is present in the urine test completed.
5. History of or findings of overweight, elevated blood pressure, cardiovascular or genitourinary disease or diabetes mellitus.
6. Either parent, or a brother or sister has or had diabetes.

Details of "Yes" answers. (Identify item.)

Examined at: ☐ applicant's residence ☐ applicant's business ☐ examiner's office on: _____, year _____, at: _____ ☐ a.m. ☐ p.m.

Signature of Examiner: _____ ☐ M.D. or ☐ D.O. ☐ Paramedic

Examiner's Social Security Number or Taxpayer Identification Number: _____ Examiner's Address: _____

At request of: _____ (Producer) Agency Address: _____

UNIFI®
Companies

Application for Insurance
Authorization

Acacia Life Insurance Company
P.O. Box 81889, Lincoln, NE 68501
800-745-1112, Fax 402-467-7335
(Client Service Department)

Ameritas Life Insurance Corp.
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P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218

Authorization to Obtain and Disclose Information

I authorize any health care providers, hospitals, insurers, the Medical Information Bureau, Inc.("MIB"), consumer reporting agency, government agency, financial institution, and/or accounting, educational institution, or employer; having data or facts about the proposed Insured's or claimant's physical or mental condition, medical care, advice, treatment, the use of drugs, alcohol, or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, education records, employment status or other relevant data or facts about the proposed Insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to the companies listed above ("the Companies"), their reinsurers, or any other agent or agency acting on the Companies' behalf.

Data or facts obtained will be released only: (1) to reinsurers; (2) to MIB; (3) to persons performing business duties as directed or contracted for by the Companies related to the proposed Insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government officials when necessary to prevent or prosecute fraud or other illegal acts; and (6) to any person or entity having an authorization expressly permitting the disclosure. The personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

The above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or materially misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed Insured or claimant.

I agree that this authorization is valid for two and one-half years from the date shown below. I also agree that a copy is as valid as the original. I, or my authorized representative, am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Companies; (2) revoking this authorization will not affect any prior action taken by the Companies in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Companies' ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

Dated at: _____
City State Month Day Year

_____
Print or Type Name of Proposed Insured

X _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

_____
Print or Type Name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

_____
Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(Attach documentation in support of your authority.)

This Authorization complies with the HIPAA Privacy Rules.