APPLICATION FOR LIFE INSURANCE - PART 2
MEDICAL QUESTIONNAIRE

☒ **Allstate Assurance Company, P.O. Box 660191, Dallas, TX 75266-0191**
☐ **Allstate Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191**

Name (First, Middle, Last)

Birth Date (MM/DD/YYYY)

Policy Number

TOBACCO AND NICOTINE USAGE

1. Which best describes your usage of tobacco and nicotine products?

☐ Never used ☐ Used more than 5 years ago
☐ Currently Using ☐ Used in the last 5 years but not currently Provide date of last use: _____ MM/YYYY

For current use and use in the last 12 months provide type(s) and quantity/frequency:

☐ Cigarettes	Quantity: _____	cigarettes per	☐ Day	☐ Month	☐ Year	
☐ Cigars	Quantity: _____	cigars per	☐ Day	☐ Month	☐ Year	
☐ Smokeless Tobacco	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ E-Cigarettes, vape pen, or other Electronic Nicotine Delivery System	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Pipe	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Nicotine gum/patch	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Other _____	Frequency: _____	per	☐ Day	☐ Month	☐ Year	

2. In the last 5 years, have you used marijuana or THC in any form? ☐ Yes ☐ No
   a. ☐ Recreational ☐ Medicinal
   b. ☐ Smoked/Inhaled ☐ Eaten/Ingested ☐ Vaporized
   c. Frequency: _____ per ☐ Day ☐ Month ☐ Year
   d. Date of last use: _____ MM/YYYY

HEALTH AND MEDICAL HISTORY

1. Primary Care Physician or Medical Provider Information

Physician's Name (First and Last) Phone Number

Address (include street, city, state, zip)

Date (MM/DD/YYYY) and Reason Last Consulted

Results of last consultation (including any diagnoses, test results, treatment, and referrals)

2. Do you have a natural parent or sibling who has been diagnosed or treated by a licensed member of the medical profession for a heart disorder, stroke or cancer beginning before age 60? (If "yes," complete table below.) ☐ Yes ☐ No

Relative	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living
☐ Mother ☐ Father ☐ Sister ☐ Brother					
☐ Mother ☐ Father ☐ Sister ☐ Brother					
☐ Mother ☐ Father ☐ Sister ☐ Brother					

Give details of all "yes" answers in chart after Question 8 below.

3. Have you ever been diagnosed, treated, or given advice by a licensed member of the medical profession for:
   a. High blood pressure, chest pain, a heart attack, coronary artery disease, heart murmur or valve disorder, irregular heartbeat, heart enlargement or other disorder of the heart? ☐ Yes ☐ No
   b. Cerebrovascular disease, a stroke or mini stroke, aneurysm, blood clot or other disorder of the blood vessels? ☐ Yes ☐ No
   c. A polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma, Hodgkin's disease or any disorder of the lymph nodes? ☐ Yes ☐ No
   d. Diabetes, high blood sugar, glucose intolerance, or disorder of the pituitary, thyroid or other endocrine gland? ☐ Yes ☐ No

4. Have you ever received treatment or advice from a licensed member of the medical profession for alcohol or drug abuse, or been advised by a licensed member of the medical profession to reduce or discontinue use of alcohol or drugs? ☐ Yes ☐ No

5. Have you ever been diagnosed by a licensed member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

6. Within the last 10 years, have you been diagnosed, treated, or given advice by a licensed member of the medical profession for:
   a. A seizure, epilepsy, syncope or fainting, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or other disorder of the brain or nervous system? ☐ Yes ☐ No
   b. Anxiety, ADHD, depression, bipolar disorder, PTSD, schizophrenia or other mental or psychiatric illness? ☐ Yes ☐ No
   c. Asthma, emphysema, COPD, chronic bronchitis, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or other disorder of the lungs or shortness of breath? ☐ Yes ☐ No
   d. An ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, blood in stool, Crohn's disease, weight loss surgery or other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☐ No
   e. Anemia or other disorder (excluding HIV) of blood, blood cells, blood clotting, or bone marrow? ☐ Yes ☐ No
   f. Nephritis, polycystic kidney disease, blood in urine, or other disorder of the bladder, kidney, urinary tract, prostate or other reproductive organs? ☐ Yes ☐ No
   g. Arthritis, gout, back trouble, chronic pain syndrome, fibromyalgia, lupus, chronic fatigue syndrome, psoriasis or other autoimmune disorder or disorder of the skin, bones, joints or muscles? ☐ Yes ☐ No

7. Other than disclosed in response to previous questions, in the last 5 years have you:
   a. been hospitalized or examined by, or received treatment (including surgery), testing or advice from a licensed member of the medical profession? ☐ Yes ☐ No
   b. been advised by a licensed member of the medical profession to have a consultation, diagnostic test or surgery that has not been done? ☐ Yes ☐ No

8. Are you taking any prescription medications not disclosed in response to previous questions? ☐ Yes ☐ No

Details of "yes" answers to Questions 3 - 8:

Question Number	Medical Condition and How It Was Treated	Dates (MM/DD/YYYY)	Most Recent Test Results	Name and Address of Physician/ Medical Provider

Answer Questions 9a-e only if Proposed Insured is age 70 or older. Give Details of "Yes" answers below.

9. Within the last year, have you:
   a. Used any of these devices to assist with mobility: wheelchair, cane, crutches, walker, leg braces, mobility scooter, transfer aid or chair lift? ☐ Yes ☐ No
   b. Resided in a nursing home, residential care or assisted living facility? ☐ Yes ☐ No
   c. Received home health care services or physical therapy? ☐ Yes ☐ No
   d. Received treatment by a licensed member of the medical profession for a fall? ☐ Yes ☐ No
   e. Needed assistance with bathing, eating, dressing, toileting, transferring into or out of bed or chair, taking medication, doing housework, preparing meals, or managing money? ☐ Yes ☐ No

Details of "yes" answers to question 9a-e:

Question Number	Medical Condition and How It Was Treated	Dates (MM/DD/YYYY)	Most Recent Test Results	Name and Address of Physician/ Medical Provider

SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief.
I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

Signed at (City, State) _____ Date (MM/DD/YYYY) _____

Signature of Proposed Insured _____ Signature of Examiner as Witness _____

MEDICAL EXAMINER'S REPORT

1. Height	2. Weight	3. Did you weigh?	4. Did you measure?
_____ft. _____in.	_____ lbs.	☐ Yes ☐ No	☐ Yes ☐ No

5. In the last 12 months, has the Proposed Insured had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No
If yes, provide amount and details: _____

6. Blood Pressure (Systolic/Diastolic)	Obtain 3 readings			7. Pulse Rate	Irregularities/min.
	_____ / _____	_____ / _____	_____ / _____	_____	_____

8. Was the Medical Questionnaire completed with the assistance of a translator? ☐ Yes ☐ No If "yes", complete 8a - 8c

a. Proposed Insured's language? _____

b. Name of translator? _____

c. Relationship of translator to the Proposed Insured? _____

COMPLETE FOR PHYSICIAN EXAMS ONLY

9. Is/are there any:

a. Heart enlargement? ☐ Yes ☐ No

b. Dyspnea or rales? ☐ Yes ☐ No

c. Carotid bruits? ☐ Yes ☐ No

d. Cyanosis or edema? ☐ Yes ☐ No

e. Other signs of CHF, CAD, or PVD? ☐ Yes ☐ No

10. Are there any heart murmurs? ☐ Yes ☐ No

Murmur is: ☐ Constant ☐ Inconstant

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic

Grade: ☐ Soft (1-2) ☐ Mod. (3-4) ☐ Loud (5-6)

Location: _____

Transmission: _____

11. Are there any abnormalities of:

a. Eyes, ears, nose, mouth, pharynx? ☐ Yes ☐ No

b. Skin (including scars), lymph nodes, blood vessels? ☐ Yes ☐ No

c. Nervous system (including reflexes, gait, paralysis)? ☐ Yes ☐ No

d. Respiratory system? ☐ Yes ☐ No

e. Abdomen (including scars)? ☐ Yes ☐ No

f. Genitourinary system (including prostate)? ☐ Yes ☐ No

g. Endocrine system (including thyroid)? ☐ Yes ☐ No

h. Musculoskeletal system (including spine, joints, amputations, deformities)? ☐ Yes ☐ No

12. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

13. Do you have any information or observations that have not already been noted or are inconsistent with stated history? ☐ Yes ☐ No

14. Do you have any relationship or business association with Proposed Insured? ☐ Yes ☐ No

EXPLANATIONS AND DETAILS OF ALL "YES" ANSWERS

How did you identify the Proposed Insured? _____

Examiner's Signature _____ Date (MM/DD/YYYY): _____

Examiner's Address: _____ Examiner's Phone Number: _____

IF PROPOSED INSURED IS AGE 70 OR OLDER, COMPLETE SENIOR ASSESSMENT.