STATEMENTS TO THE MEDICAL EXAMINER

In Continuation of and Forming a Part of My Application for Insurance to

American-Amicable Life Insurance Company of Texas

PART TWO Mail examination to: Underwriting Department / P.O. Box 2549 / Waco, Texas 76702-2549

1. Applicant (Please Print)	Birth Date: Month Day Year / /	Driver's License #	State
		SS# — —	

2. (a) Name and address of your personal physician? _____
(If none, so state)
(b) Date and reason last consulted? _____
(c) What treatment was given or medication prescribed? _____
(d) List all current medications including herb and vitamin supplements. _____

	Yes	No
3. To the best of your knowledge and belief do you have, or have you ever had, or been treated for (circle condition that applies):		
(a) Asthma, pneumonia, bronchitis, emphysema, tuberculosis or any disease or disorder of the lungs or respiratory system?	☐	☐
(b) Dizziness, epilepsy, seizure, paralysis, head injury, or any mental or nervous disorder?	☐	☐
(c) Albumin, protein, sugar or blood in urine; any disease or disorder of the kidneys or genitourinary system?	☐	☐
(d) Arthritis or any disease or disorder of the muscles, bones, joints, or back?	☐	☐
(e) Any disease or disorder of the ears, eyes, nose or throat?	☐	☐
(f) Chest pains, heart attack, stroke, transient ischemic attack (TIA), high blood pressure, shortness of breath, heart murmur, phlebitis, blood clot; any disease or disorder of the heart or circulatory system?	☐	☐
(g) Cirrhosis, hepatitis, or any disease or disorder of the gastrointestinal tract?	☐	☐
(h) Malignancy, cancer or other tumors or cyst?	☐	☐
(i) Diabetes, thyroid, or endocrine disorders?	☐	☐
(j) Anemia or any disease or disorder of the blood?	☐	☐
4. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any disease or disorder of the immune system?	☐	☐
5. Have you ever used: Heroin, morphine, cocaine, LSD, marijuana or abused prescription medication? (If Yes, indicate amount and how often and date last used)	☐	☐
6. (a) Do you currently drink alcohol? (If Yes, circle type: beer, wine, liquor. Indicate amount and frequency)	☐	☐
(b) Have you ever received treatment for excessive drug or alcohol usage? (If Yes, give date of treatment and last usage)	☐	☐
7. (a) Have you been arrested in the past 10 years? (If Yes, give details to include when, where, charges, and final outcome)	☐	☐
(b) Have you had a DWI or DUI or had your Driver's License suspended or revoked in the past 10 years? (If Yes, explain)	☐	☐
8. Do you have a tattoo? (If Yes, date done)	☐	☐
9. In the past 5 years, have you consulted, or been treated or examined by any physician, psychologist, psychiatrist or practitioner not named above for any cause not recorded above?	☐	☐
10. Have you used tobacco or any nicotine products in any form within the past twelve (12) months? (If Yes, type and amount, if No, date last used)	☐	☐
11. If the applicant is a woman: Are you currently menstruating?	☐	☐
12. Has the natural parent, brother or sister of the proposed insured ever had tuberculosis, diabetes, cancer, heart disease, kidney disease or mental illness?	☐	☐

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Siblings			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief. I agree that these statements and answers are to be considered as the basis of any insurance written hereon.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has knowledge or records of me and my health to give such information to American-Amicable Life Insurance Company of Texas and its reinsurers.

Signed at _____ this _____ day of _____ , _____ (Year)

Witness _____ (Examiner) X _____ (Signature of Applicant)

AA9377

PART THREE

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

13. (a) Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

(b) Did you weigh? ☐Yes ☐No (c) Did you measure? ☐Yes ☐No

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

15. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

16. Blood Pressure:
Systolic 1_____ 2_____ 3_____
Diastolic (5th phase, end of sound) _____ _____ _____
If over 140 or 90 or under treatment report several readings.

17. Is applicant presently under anti-hypertensive medication? ☐Yes ☐No

Details of "Yes" answers (Identify item).

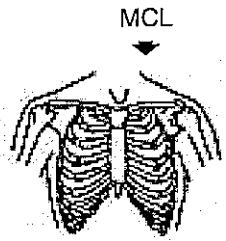
PHYSICIAN STATEMENT

18. Is there evident arteriosclerosis? ☐Yes ☐No

19. Heart:
Is there any:
Enlargement? ☐Yes ☐No Dyspnea? ☐Yes ☐No
Murmur(s)? ☐Yes ☐No Edema? ☐Yes ☐No
(Describe below — if more than one, describe separately.)

Location	Murmur 1	Murmur 2
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
Murmur area by O
Point of greatest intensity by O
Transmission by ➧



For comments and your impression

20. Is there on examination any abnormality of the following: (Circle applicable items and give details.)	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree.)	☐	☐
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
21. Are there any hernias?	☐	☐
22. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar	IMPORTANT Please forward urine and/or blood specimen(s) to the Laboratory shown on the container provided.
(a) Is specimen being sent? ☐Yes ☐No			(b) Blood Study: Is sample being sent to lab shown on container? ☐Yes ☐No

I CERTIFY I made this examination in private at ☐My office, ☐Applicant's office, ☐Applicant's home. at_____ ☐A.M. ☐P.M.

in_____ this_____ day of_____, _____
City State

Signature: _____ Address: _____
Medical Examiner

AA9377

Insurer Name: _____ Address: _____

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

x _____

Signature of Proposed Insured or Parent/Guardian — Date Signed

_____

Name and Address of Proposed Insured (Please Print)