AMERICAN NATIONAL
American National Life Insurance Company of Texas

Statements to Medical Examiner

Issued by American National Life Insurance Company of Texas
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: PO Box 696700, San Antonio, TX 78269-6700 Business (800) 899-6806 Fax (888) 237-1012

* M E D E *

1. Proposed Insured's Name: Last _____ First, M.I. _____ Date of Birth (Mo-Day-Yr) ☐☐☐ Sex: M ☐ F ☐

Name, address, and phone number of personal physician (If none, state "none")

Name of doctor: _____ Date last seen: _____

Address/Phone: _____ Reason for last visit: _____

	YES	NO
2. **Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession ...**		
a) for a heart attack, high blood pressure, chest pain, angina, congestive heart failure, heart murmur, irregular heart beat, heart valve disease or any disease or disorder of the heart or arteries?	☐	☐
b) for a stroke, cerebral vascular accident (CVA), Transient Ischemic Attack (TIA), aneurysm, or peripheral vascular disease (PVD)?	☐	☐
c) for cancer, leukemia, lymphoma, malignant melanoma or any other malignancy?	☐	☐
d) for diabetes, elevated blood sugar, impaired glucose intolerance or impaired fasting glucose?	☐	☐
e) for human immunodeficiency virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?	☐	☐
3. **Have you, in the last ten years, been diagnosed or treated by a member of the medical profession for ...**		
a) Seizures, epilepsy, or convulsions?	☐	☐
b) Multiple Sclerosis (MS), ALS (Lou Gerhig's disease), muscular dystrophy, or Parkinson's disease?	☐	☐
c) Asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, chronic obstructive pulmonary disease (COPD), or any disease or abnormality of the respiratory system?	☐	☐
d) Cirrhosis, hepatitis, ulcerative colitis, Crohn's disease, disease of the pancreas, esophagus, ulcer or any other disease or disorder of the stomach or intestines?	☐	☐
e) Anemia, blood disorder, clotting or bleeding disorder, or any lymph node disorder?	☐	☐
f) Arthritis, fibromyalgia, or any disease of the bones, muscles or joints?	☐	☐
g) Lupus, rheumatoid arthritis, scleroderma, polymyositis, dermatomyositis or any connective tissue disease?	☐	☐
h) Injuries associated with falls or imbalance?	☐	☐
I) Disease of the prostate or genital system?	☐	☐
j) Disease of the kidneys, bladder, urinary tract, protein or blood in the urine?	☐	☐
k) Depression, anxiety, psychiatric treatment or counseling, or any disease or abnormality of the brain or nervous system?	☐	☐
4. **Within the past 10 years have you ...**		
a) Been advised by a member of the medical profession to reduce or discontinue use of alcohol or drugs?	☐	☐
b) Received treatment or counseling by a member of the medical profession for the use of alcohol or drugs?	☐	☐
5. **Within the past 5 years have you ...**		
a) had an operation or been hospitalized by a member of the medical profession for any illness, disease or accident?	☐	☐
b) had any diagnostic testing by a member of the medical profession (EKG or other cardiovascular test, X-ray, blood, or other laboratory test)?	☐	☐
6. Are you currently being prescribed any medications or under any treatment by a member of the medical profession? (please list medications/treatment)	☐	☐
7. Has your weight changed by more than 10 lbs in the past year?	☐	☐

Give full details below of all "Yes," answers to questions 2 through 11. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICATION ITEMS: Include diagnosis dates, duration and names and addresses of all attending physicians and medical facilities.)

Attach an additional sheet of paper, if necessary.

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	YES	NO
8. Have you received any disability benefits in the past 5 years due to accident or illness?	❑	❑
9. Within the past 5 years, have you been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	❑	❑
10. Have you ever used tobacco or nicotine in any form? (Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine.) If "Yes," when was tobacco or nicotine last used? Month/Year _____	❑	❑
11. Has a parent or sibling been diagnosed or treated by a member of the medical profession for: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	❑	❑

	Age if Living?	Age At Death?	Cause of death?			Age if Living?	Age At Death?	Cause of Death
Father				Brothers and Sisters No. Living				
Mother				No. Dead				

I hereby represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief, and I understand that they shall form a part of my application for insurance with American National Life Insurance Company of Texas.

Signed at _____ this _____ day of _____, _____.
Month Year

_____ _____
Signature of Witness Signature of Proposed Insured

(To be completed and signed in presence of medical examiner.)

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MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

12. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, At Umbilicus Relaxed
Ft. In.	Lbs.	In.	In.	In.

Did you weigh? ❑ Yes ❑ No Did you measure? ❑ Yes ❑ No

Weight change in the past year _____ lbs. ❑ Gain ❑ Loss

Is appearance unhealthy or older than stated age? ❑ Yes ❑ No

13. BLOOD PRESSURE: All readings must be taken in a sitting position. If first reading is over 140/90 make two additional observations at 10 minute intervals.

	Rest	2nd	3rd
Systolic			
Diastolic (5th Phase)			

14. Pulse Rate:

	Before Exercise	Immediately After	Three Minutes After
Pulse Rate			
Irregularities			

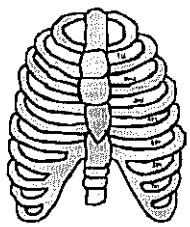
15. Heart:

		Yes	No
(a)	Is there any evidence of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder?	❑	❑
(b)	Is there any history of Rheumatic fever?	❑	❑
(c)	Is heart enlarged? (If yes, describe)	❑	❑
(d)	Is murmur present? (If yes, complete 15e)	❑	❑

(e) Murmur is: ❑ Systolic ❑ Apical ❑ Soft (Gr. 1-2) ❑ Constant ❑ Transmitted ❑ Presystolic ❑ Basal ❑ Mod. (Gr. 3-4) ❑ Inconstant ❑ Localized ❑ Diastolic ❑ Other ❑ Loud (Gr. 5-6)
After exercise is murmur: ❑ Unchanged ❑ Increased ❑ Decreased ❑ Absent

(f) If more than one murmur is present, explain under details at right.

Show location of:
Apex by X
Area of murmur by ⋯
Point of greatest intensity by ○
Transmission by →



Your diagnosis of any cardiovascular abnormality _____

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.)

Attach an additional sheet of paper, if necessary.

16. 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 is markedly impaired, indicate degree and correction.)	❑	❑
(b) Skin (incl. scars); lymph nodes; blood vessels (incl. varicose veins)	❑	❑
(c) Nervous system (include reflexes, gait, paralysis)	❑	❑
(d) Respiratory system	❑	❑
(e) Abdomen (including scars or hernia)	❑	❑
(f) Genito-Urinary system (include prostate)	❑	❑
(g) Endocrine system (include thyroid and breasts)	❑	❑
(h) Musculoskeletal system (include spine, joints, amputations, deformities)	❑	❑
17. Have you any pertinent information not found on examination or brought out in statements to medical examiner on reverse side?	❑	❑
18. Are you related to the person examined or the Agent/Insurance Producer?	❑	❑

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19. URINALYSIS: (To be done in all cases.)
Send specimen to laboratory in all cases. Specific Gravity: _____ Alb. _____ Sugar _____

FRAUD WARNING:

Any person who knowing presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I certify that I examined _____ at _____ A.M./P.M. on the _____ day of _____, _____
(Name of Applicant) Month Year

Examination made at my office _____, Individual's office _____, Individual's home _____, other _____

Examiner's Signature: _____, Examiner's Address: _____

SS# ☐☐☐ or Tax I.D.# ☐☐☐

EXAMINER'S VOUCHER
(Do not detach)

Medical Examiner _____

SS# ☐☐☐ or Tax I.D.# ☐☐☐

Fee $ _____

Address of Examiner _____

Name of Person examined _____

Name of Agent/Insurance Producer _____ Agency _____

Date of Examination _____