Paramed Exam Form

American United Life Insurance Company®
a OneAmerica® company
One American Square
P.O. Box 368
Indianapolis, IN 46206-0368
(317) 285-1877

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® company
101 North 10th Street
Fargo, ND 58102
(701) 297-5700

The State Life Insurance Company
a OneAmerica® company
P.O. Box 406
Indianapolis, IN 46206
(317) 285-2300

OneAmerica®

ANSWERS MADE TO THE MEDICAL EXAMINER

Please print or type. Use black ink. Do not use dashes or ditto marks.

Full Name of Proposed Insured	*Date of Birth*	*Social Security Number*

Name and Address of Personal Physician *(If none, state "None".)* _____

Date, reason and results of Proposed Insured's last doctor visit or consultation. _____

1. Is the Proposed Insured now under observation, receiving treatment or taking medication prescribed by a member of the medical profession?	☐ Yes	☐ No
2. In the past 10 years, has the Proposed Insured ever been diagnosed as having, been treated for or ever had *(Circle Applicable Items)*:		
a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels?	☐ Yes	☐ No
b. Cancer, tumors, Kaposi's sarcoma, disorder of the skin, swelling of the lymph glands, fever of unknown origin, night sweats, lupus or collagen disorder, arthritis or any bone or muscle disease?	☐ Yes	☐ No
c. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, Alzheimer's, senile dementia, nervous or mental disorder including anxiety, depression, attempted suicide or a suicidal gesture?	☐ Yes	☐ No
d. Shortness of breath, persistent hoarseness or cough, blood spitting, pneumocystis carinii pneumonia, bronchitis, asthma, emphysema, tuberculosis, allergies, sleep apnea, or other chronic respiratory system disorder?	☐ Yes	☐ No
e. Diabetes, thyroid or other endocrine disorder, elevated blood sugar, albumin, blood, sugar or pus in the urine, stone or other disease of kidney, bladder, prostate or reproductive organs?	☐ Yes	☐ No
f. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of the stomach, intestine, gallbladder or spleen?	☐ Yes	☐ No
g. Hepatitis, cirrhosis or other disorder of the liver or pancreas?	☐ Yes	☐ No
h. Anemia, bleeding tendency or other disorder of the blood?	☐ Yes	☐ No
i. Disorder of eyes, ears, nose or throat?	☐ Yes	☐ No
j. Deformity, lameness or amputation?	☐ Yes	☐ No
k. Any indication, diagnosis or treatment of alcohol or drug dependency, abuse or reaction?	☐ Yes	☐ No
l. Is the Proposed Insured pregnant? If yes, due date _____	☐ Yes	☐ No
3. Within the past 5 years, has the Proposed Insured *(Circle Applicable Items)*:		
a. Had a checkup, consultation, illness, injury or surgery?	☐ Yes	☐ No
b. Had a diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study?	☐ Yes	☐ No
c. Been a patient in a hospital, clinic, sanitarium, extended care facility, nursing home, hospice or other medical facility?	☐ Yes	☐ No
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed or where results are still pending or have a doctor's appointment scheduled?	☐ Yes	☐ No
e. Had any condition resulting in over 10 consecutive days of time lost from work or required assistance for a period longer than one week pertaining to activities of daily living; such as bathing, dressing, continence, eating, toileting and transferring?	☐ Yes	☐ No
f. Requested or received home nursing or home healthcare, a pension, benefits or payment because of injury, sickness or disability?	☐ Yes	☐ No

4. Record details of "Yes" answers. IDENTIFY QUESTION NUMBER. Include all dates, diagnoses, names and addresses of all attending physicians and medical facilities.*(Enter additional details on page 2.)*

Details of "Yes" answers continued:

5. Family History:

	Age if still Living	Age at Death	State of Health/ Cause of Death	Cancer (Any type)	Heart disease, stroke or circulatory disorder	Diabetes
Mother				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Father				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Siblings				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6. Nicotine and/or Tobacco Use:
   a. ☐ Never ☐ Present ☐ Former
   b. Type of nicotine or tobacco used: _____
   c. When did the Proposed Insured quit using all forms of nicotine or tobacco? *(month/year)* _____

7. Immune Deficiency – Has the proposed insured:
   a. ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia; ☐ Yes ☐ No
   b. diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS). ☐ Yes ☐ No

I have read the statements and answers made above. They are, to the best of my knowledge and belief, true, complete and correctly recorded. This supplement will become a part of my application for insurance and will be a part of the basis of any insurance issued.

Signed at _____ *City* _____ *State*, on _____ *Date*

_____ *Signature of Proposed Insured*

Witness _____ *Signature of Representative*

Medical Examiner's Report

(Paramedical Technician: Complete sections 1, 2 (a,b,c), 4, 5, 6, 7 and 8.)
(Physicians: Complete all sections.)

INSTRUCTIONS TO THE MEDICAL EXAMINER: Answers must be in your handwriting. Any erasures or alterations in this report should be initialed by you. Record details of "Yes" answers in #8. If you prefer to do so, you may send this report, or any information which you prefer not to include in this report, directly to the Medical Director of the Company, P.O. Box 6003, Indianapolis, IN 46206.

Proposed Insured's Name: _____

1. a. Height _____ft. ____in.
   Weight _____lbs.
   Males only:
   Chest (full inspiration) _____in.
   Chest (forced expiration) _____in.
   Abdomen (at umbilicus) _____in.
   b. Did you weigh? ☐ Yes ☐ No
   c. Any change in weight in the past year?
   ☐ Yes ☐ No
   If yes, loss _____lbs. / gain _____lbs
   d. Reason for any change? _____

2. Cardiovascular Examination:
   a. Blood Pressure (sitting) – Please take 3 readings

	1st	*2nd*	*3rd*
Systolic	_____	_____	_____
Diastolic	_____	_____	_____

   b. Pulse Rate _____
   c. Irregularities _____
   d. Is the heart enlarged? ☐ Yes ☐ No
   e. Is there a murmur? ☐ Yes ☐ No
   TIMING: ☐ Systolic ☐ Presystolic ☐ Diastolic
   INTENSITY: ☐ Systolic ☐ Presystolic ☐ Diastolic
   f. In your opinion, would you describe the murmur as:
   ☐ Functional ☐ Organic

3. Do you find any evidence of past or present disease or abnormality of *(Circle Applicable Items)*:
   a. Head and/or neck? ☐ Yes ☐ No
   b. Eyes, ears, nose or throat? ☐ Yes ☐ No
   c. Brain or nervous system? ☐ Yes ☐ No
   d. Lungs or chest? ☐ Yes ☐ No
   e. Abdomen? ☐ Yes ☐ No
   f. Genito-urinary system? ☐ Yes ☐ No
   g. Extremities or peripheral vessels? ☐ Yes ☐ No
   h. Skin? ☐ Yes ☐ No
   i. Any other parts of the body? ☐ Yes ☐ No

4. Are you aware of any additional medical history or obvious abnormalities concerning the Proposed Insured? ☐ Yes ☐ No

5. Are you and the Proposed Insured related or are you and the Proposed Insured business or professional associates? ☐ Yes ☐ No

6. How did you identify the Proposed Insured? (if related, explain in #8)
   ☐ Well known to you ☐ Photo ID ☐ Related

7. Examination was done:
   at ☐ Office ☐ Residence
   of ☐ Examiner ☐ Proposed Insured
   at _____ ☐ A.M. ☐ P.M.

8. DETAILS of "Yes" answers. (If you are the attending physician, please attach a copy of the patient's records.)
   _____
   _____
   _____
   _____

I certify that I have personally asked all questions and accurately recorded the answers. I personally performed the physical measurements and recorded my observations.

Signed at: _____ Date _____
City *State*

_____ _____
Signature of Examiner *Printed Name*

Name of Paramedical Company: _____ Phone No.: _____

_____
Address *City* *State* *Zip Code*

If the Examiner is an M.D., name of Specialty: _____
☐ Board Certified ☐ Board Eligible