Please print or type names and addresses.

PARA MEDICAL/MEDICAL REPORT - Part 2

Supplement to Application to: **THE AMERICAN HOME LIFE INSURANCE COMPANY**

400 Kansas Ave. • P.O. Box 1497
Topeka, Kansas 66601-1497

1. Name of Proposed Insured:	Birthdate	Sex	Name of Agent

MEDICAL HISTORY (to be recorded by examiner):

Examination made in private at: { [ ] Examiner's office [ ] Proposed Insured's Home [ ] Proposed Insured's Office

___ A.M. ___ P.M.

	YES	NO
2. Is there any history in parents, brothers or sisters of:		
a. Diabetes, heart or kidney disease, high blood pressure?	[ ]	[ ]
b. Death before age 60? (relationship, age, cause of death?)	[ ]	[ ]
3. Has your weight changed more than 10 pounds in the past year? If yes, gained _____lbs; lost _____lbs. Reason for change? _____ How long has present weight been stationary?_____	[ ]	[ ]
4. When did you last consult a physician? Month _____ Year _____ (Give particulars in #13 below.)		
5. Are you now being treated or taking medication for any condition or disease?	[ ]	[ ]
6. Have you used tobacco in any form in the last 12 months? (If yes, give particulars in #13 below)	[ ]	[ ]
7. Have you ever:		
a. had any surgical operations?	[ ]	[ ]
b. been in any hospital, sanitarium, or other institution for observation, rest, diagnosis or treatment?	[ ]	[ ]
c. used barbiturates or amphetamines, or heroin, opiates, or other narcotics, except as prescribed by a doctor, or ever been treated or counseled for alcoholism?	[ ]	[ ]
8. Have you ever been treated by any doctor for or had any known indication of:		
a. high blood pressure?	[ ]	[ ]
b. chest pain, pressure or discomfort?	[ ]	[ ]
c. heart murmur, or rheumatic fever?	[ ]	[ ]
d. asthma, emphysema, or tuberculosis?	[ ]	[ ]
e. tumor, cancer, diabetes, or syphilis?	[ ]	[ ]
f. nervous trouble, epilepsy, or any mental disorder?	[ ]	[ ]
9. Other than previously disclosed, have you ever been treated by any doctor for or had any known indication of any disease or disorder of the:		
a. heart, arteries, or veins?	[ ]	[ ]
b. lungs, chest or throat?	[ ]	[ ]
c. brain or nervous system?	[ ]	[ ]
d. liver, gallbladder, stomach, intestines, or rectum?	[ ]	[ ]
e. kidneys, bladder, genital organs, or urinary tract?	[ ]	[ ]
f. spine, joints, skull, or other bones?	[ ]	[ ]
g. blood, glands, or skin?	[ ]	[ ]
(1) enlarged lymph glands?	[ ]	[ ]
(2) unusual skin rashes?	[ ]	[ ]
h. ears, eyes, nose, or sinuses?	[ ]	[ ]
10. Have you, within the past 5 years:		
a. had any electrocardiograms, X-rays for treatments or diagnostic purposes, or any blood, urine, or other medical tests?	[ ]	[ ]
b. been advised by a doctor to have any operation which has not been performed?	[ ]	[ ]
c. made claim for or received benefits, compensation, or a pension because of sickness or injury?	[ ]	[ ]
11. Have you ever been treated for or diagnosed as having AIDS, ARC (AIDS Related Complex), any immunological disorder, or tested positive on an AIDS related blood test?	[ ]	[ ]
12. Do you have any known indication of any other physical disorder or abnormality?	[ ]	[ ]

13. Give full particulars to ALL questions above answered "Yes." (If additional space in needed, please continue on back of form over signature of proposed insured.)

Question No.	Name of Disease, Sympton, Injury, Etc.	Date of Onset	Duration	Number of Attacks	Names and Addresses of Attending Physicians and Hospitals

It is understood and agreed that all statements and answers given above are true and complete to the best of my knowledge and belief which are offered to the Company as a consideration for and shall be a part of any policy issued.

Witnessed _____ Signed _____ Dated _____

Medical Examiner Proposed Insured

Form No. U-9-7/98 **PLEASE COMPLETE REVERSE SIDE**

THE AMERICAN HOME LIFE INSURANCE COMPANY **PARA MEDICAL/MEDICAL REPORT -** Part 3

EXAMINATION OF:
(Print full name)

PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN "DETAILS" SPACE BELOW.

14. Height		15. Weight		16. Girth-Chest		17. Girth-Abdomen
Ft.	In.	Present	1 Year Ago	Insp.	Exp.	

18. Pulse Rate	If pulse is irregular enter no. per minute	

19. Blood Pressure	Systolic	Diastolic (Phase V)
1st Reading		
Additional		

IF BLOOD PRESSURE IS ABNORMAL, record additional readings after five minutes.

25. Urinalysis — See note below

Specific Gravity	Albumin	Sugar

YES NO

a. Are you satisfied specimen is authentic? ..... ☐ ☐

b. Are you forwarding specimen to Home Office? ☐ ☐

Note: **ALWAYS** Send specimen to the Laboratory specified on the urine mailing kit.

26. Have you any pertinent information affecting proposed insured not brought out above? ..... ☐ ☐

QUESTIONS 20-24 TO BE COMPLETED BY LICENSED PHYSICIAN ONLY

On inquiry and examination, is there evidence of —

	YES	NO
20. Present or past diseases or abnormalities of:		
a. Brain, nervous system? (test reflexes; coordination)	☐	☐
b. Eyes, ears, nose, throat, teeth, gums?	☐	☐
c. Thyroid or lymph glands?	☐	☐
d. Lungs or respiratory system?	☐	☐
e. Abdominal organs?	☐	☐
f. Genito-urinary organs?	☐	☐
g. Skeletal structure?	☐	☐
h. Unusual skin rashes?	☐	☐
21. Any evident sign or symptom to suggest presence of AIDS or AIDS Related Complex?	☐	☐
22. Varicose veins or ulcers?	☐	☐
23. Arteriosclerosis; other peripheral vascular disease?	☐	☐
24. Present or past diseases or abnormalities of heart or blood vessels? (If yes, complete questions 24a. through g.)	☐	☐

DETAILS
QUESTIONS 20-24

REQUIRED WHEN QUESTION 24 IS ANSWERED "YES"

	YES	NO
a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?	☐	☐
b. Is there hypertrophy? (If yes, state degree)	☐	☐
c. Is there a murmur?	☐	☐

Type: ☐ Systolic ☐ Diastolic ☐ Presystolic
Quality: ☐ Soft ☐ Rough ☐ Blowing
Intensity: ☐ Faint ☐ Moderate ☐ Loud
Location: ☐ Apex ☐ Aortic ☐ Pulmonic

d. Is murmur constant?	☐	☐		
e. Is murmur transmitted?	☐	☐		
If yes, where? _____				

f. EXERCISE TEST — 50 vigorous hops	Pulse Rate	Irregularities No. Per Minute	Murmur Present	Murmur Absent
BEFORE EXERCISE				
IMMEDIATELY AFTER				
3 MINUTES AFTER				

g. PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:

Position of apex beat X

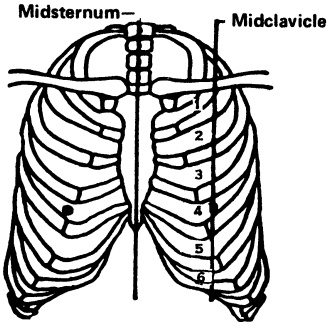
(_____ins. of _____cms. from Midsternum in _____interspace)

Murmur:

Area of distribution ..... ☐

Point of greatest intensity ..... ○

Direction of transmission ..... #



Additional space for #13 on reverse, if needed. If this space is used, obtain proposed insured's signature below.

Signed _____
Proposed Insured

MEDICAL EXAMINER:

Please print name _____ Signature _____

Address _____

Date of Examination _____

EXAMINATION FEE

$ _____

Form No. U-9-7/98

THIS REPORT MUST BE SENT DIRECT TO THE HOME OFFICE BY THE MEDICAL EXAMINER