APPLICATION FOR INSURANCE TO THE
AMERICAN INCOME LIFE INSURANCE COMPANY
Post Office Box 2608 Waco, Texas 76797

Name of Applicant _____ D.O.B. _____

Address _____

Tel. # _____ Driver's License # _____

Family Physician _____ Tel. # _____

Address _____

Date & Reason Last Consulted _____ Treatment or Medication _____

PLACE AN "X" IN THE BOX WITH THE CORRECT ANSWER

1. In the past 5 years:
   a. have you been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment? Yes No
   b. have you had an X-ray, electrocardiogram, blood study, or other diagnostic test? Yes No

2. To the best of your knowledge and belief, in the past 10 years, have you had or been treated for:
   a. dizziness, fainting spells, paralysis, epilepsy, nervous breakdown, severe headaches, or any disease or disorder of the brain or nervous system? Yes No
   b. asthma, emphysema, hay fever, chronic cough, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system including pneumocystis carinii pneumonia? Yes No
   c. high blood pressure; chest pain, shortness of breath, heart murmur, rheumatic fever, or any disease or disorder of the heart or circulatory system? Yes No
   d. any disease or disorder of the stomach, intestines or bowel, rectum, appendix, gall bladder, or hernia of any kind? Yes No
   e. cirrhosis or other disease or disorder of the liver, or abnormal liver enzyme (function) tests, or hepatitis? Yes No
   f. nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy? Yes No
   g. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? Yes No
   h. anemia goiter, or any disease or disorder of the blood, or persistent enlargement of the lymph nodes? Yes No
   i. diabetes, or sugar, albumin, or blood in the urine? Yes No
   j. cancer, tumor, or unexplained masses of any kind? Yes No
   k. varicose veins, or phlebitis? Yes No
   l. any disease or disorder of the eyes, ears, nose, throat, or skin? Yes No
   m. any sexually transmitted or venereal disease including gonorrhea, syphilis, chlamydia, genital herpes, or anal warts? Yes No
   n. persistent infection, fever, night sweats, chills, and/or diarrhea? Yes No
   o. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? Yes No
3. In the past twelve months, have you had unexplained weight loss? Yes No
4. Have you ever tested positive for antibodies to the "AIDS" virus (HIV - Human Immunodeficiency Virus)? Yes No
5. Do you use tobacco in any form? Yes No

   If yes, what? ☐ Cigarettes ☐ Cigars ☐ Chewing ☐ Snuff ☐ Pipe

   Have you used tobacco in any form in the past and quit? Yes No

   If "Yes," when did you stop? _____

6. Do you use alcoholic beverages? Yes No

   If yes, how often? _____ How many? _____

   If no, have you drunk in the past? Yes No

   If yes, when did you stop? _____

   Why? _____

7. Have you ever used:
   a. barbiturates, hallucinogens, sedatives, or tranquilizers habitually? Yes No
   b. L.S.D., marijuana, cocaine, or any amphetamine? Yes No
   c. heroin, morphine, or other narcotic drug? Yes No
8. In the past 10 years, have you been treated for alcoholism or any drug habit or been a member of A.A.? Yes No
9. Have you ever been arrested? Yes No

ONLY ASK FOLLOWING QUESTIONS IF AMOUNT APPLIED FOR EXCEEDS $100,000!

10. Do you participate in any of the following activities: Auto, Motorcycle or Boat Racing, Parachute Jumping, Skin or Scuba Diving, Hang gliding or Sky Diving? Yes No
11. Have you flown as other than a passenger of an airplane in the last two years? Yes No
12. What is your annual income? _____
13.

FAMILY RECORD	IF ALIVE Age	IF DECEASED Age at Death	IF DECEASED Cause of Death
Father			
Mother			
Brothers and Sisters			

REMARKS: Please give full details for any questions answered "Yes"

Question #	Dates & Duration	Physician Name & Address Hospital or Company. Nature of condition, treatment, results, reasons, other information

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

_____ Dated at _____ on _____

Signature of Proposed Insured City State

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Q22220

14. EXAM RESULTS:

Pulse_____ per minute

Regular ☐ Irregular ☐

Blood Pressure	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

To be taken at separate intervals, and if systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest.

Height_____ ft._____ ins. Weight_____ lbs.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

Measurements **(Male Applicants Only)**

Chest (full inspiration)_____ ins. Chest (forced expiration)_____ ins. Abdomen at umbilicus_____ ins.

15. TIMED VITAL CAPACITY

	FEV		FVC	
	TEST 1	TEST 2	TEST 1	TEST 2
MEASURED				
PREDICTED				

16. Heart:

RATE

Per min. (After 5 min. - If 1st reading more than 95 per min.) Per Min.

RHYTHM_____

Extrasystoles? ☐ Yes ☐ No If Yes, give number of extrasystoles.

(a) Before exercise	Per Min.
(b) After exercise	Per Min.

MURMUR: Present? ☐ Yes ☐ No Location_____

Timing	Quality	Loudness	Constant	Effect of Exercise on Loudness
Systolic ☐	Harsh ☐	Faint ☐	Yes ☐	Increase ☐
Diastolic ☐	Blowing ☐	Medium ☐		Decrease ☐
Presystolic ☐	Rumbling ☐	Loud ☐	No ☐	No Effect ☐
	Other ☐			

(Describe under "discussion")

Is Murmur transmitted? ☐ Yes ☐ No If Yes, give direction and extent_____

HYPERTROPHY: Present? ☐ Yes ☐ No If Yes, give location of apical impulse_____

DISCUSSION:

17. Does physical examination reveal any abnormality of:	YES	NO	If Yes, give details, State whether any present symptoms or incapacity.
(a) Lungs?	☐	☐	
(b) Stomach, liver or other abdominal organs, including hernia?	☐	☐	
(c) Brain or nervous system? (include test of major reflexes. Observe gait and mental attitude.)	☐	☐	
(d) Skeletal or muscular system, including lameness, deformity or absence of limb?	☐	☐	
(e) Peripheral vessels, including varicose veins? (Pay special attention to any evidence of arteriosclerosis.)	☐	☐	
(f) Skin and glands?	☐	☐	
(g) Eyes? (Test each eye separately: give degree and cause of any impairment.)	☐	☐	
(h) Ears, nose, throat and thyroid? (Test each ear; give degree of deafness or discharge.)	☐	☐	

18. Urinalysis	Albumin	Sugar

Is Specimen being sent to lab?

☐ Yes ☐ No

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Examiner is correctly recorded.

Examiner's Signature_____

I certify that I made this examination on the_____ day of_____.

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