Medical Exam Form AAA5100

AMERICO

Proposed Insured Name *(Last, First, Middle Initial) (please print)*	Birthdate *(mo/day/year)*

PROPOSED INSURED'S STATEMENT TO THE MEDICAL EXAMINER

Proposed Insured's personal physician: *(If none, so state)*

1. Physician's Name: _____ 2. Physician's Address: _____
3. Date and reason last consulted? _____
4. Physician's Phone Number: _____
5. What treatment was given or medication prescribed? _____

Health Questions Asked by the Medical Examiner and Answered by the Proposed Insured. Check "Yes" or "No" and circle applicable items.

		Yes	No
6.	In the past **10 years**, have you been treated for or had any known indication of:		
	a. Disorder of eyes, ears, nose, or throat?	☐	☐
	b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
	c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☐
	d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?	☐	☐
	e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver, or gallbladder?	☐	☐
	f. Sugar, Albumin, Blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, breasts, or reproductive organs?	☐	☐
	g. Diabetes; thyroid or other endocrine disorders?	☐	☐
	h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	☐	☐
	i. Deformity, lameness, or amputation?	☐	☐
	j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	☐	☐
	k. Allergies; anemia or other disorder of the blood?	☐	☐
7.	Are you **now** under observation or taking treatment?	☐	☐
8.	Have you had any change in weight in the **past year**?	☐	☐
9.	Other than the above, have you within the past **5 years**:		
	a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
	b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
	c. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
	d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
	e. Been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
10.	Are you planning to consult a doctor for any physical or mental symptoms that you have experienced within the past **60 days**?	☐	☐
11.	Have you **ever** had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
12.	Have you **ever** requested or received a pension, benefits or payment because of an injury, sickness, or disability?	☐	☐
13.	Family history: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or suicide?	☐	☐

	Age (age at death, if deceased)	Cause of Death
Father		
Mother		
Number of Brothers or Sisters: Living: ____ Deceased: ____		

Details of "Yes" answers. *Include diagnoses, dates, duration and name and address of all attending physicians and medical facilities.*

Agent's Name: _____

I represent to Americo Financial Life and Annuity Insurance Company that the above answers are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that the above answers shall form a part of my application and that the Company can rely on these answers.

Dated at _____ this _____ day of _____, _____.

Signature of Proposed Insured *(Child's Parent if Proposed Insured is under age 16)*

Signature of Medical Examiner

MEDICAL EXAMINATION REPORT (Completed by the Medical Examiner)

Height_____ (In Shoes) Weight ____ lbs. (Clothed) Chest at full inspiration ____ in. Chest at forced full expiration ____ in. Abdomen, at umbilicus _____in.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

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

Blood Pressure *(Record ALL readings. Repeat B.P. if first over 135/85.)*

Systolic			
Diastolic 4th Phase			
5th Phase			

Pulse	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

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)

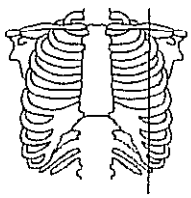
Indicate:

Apex by X

Murmur area by ☐

Point of greatest Intensity by ○

Transmission by →



Your impression? _____

Location		
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	☐	☐

On examination, is there any abnormality of the following?

Check "Yes" or "No", circle applicable item and give details.

a. Eyes, ears, nose, mouth, pharynx? *(If vision or hearing markedly impaired, indicate degree and correction.)* ☐ Yes ☐ No

b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? ☐ Yes ☐ No

c. Nervous system? *(Include reflexes, gait, paralysis)* ☐ Yes ☐ No

d. Respiratory system? ☐ Yes ☐ No

e. Abdomen? *(Include scars)* ☐ Yes ☐ No

f. Genitourinary system? *(Include prostate)* ☐ Yes ☐ No

g. Endocrine system? *(Include thyroid and breasts)* ☐ Yes ☐ No

h. Musculoskeletal system? *(Include spine, joints, amputations, deformities)* ☐ Yes ☐ No

Are there any hernias? ☐ Yes ☐ No

Are there any hemorrhoids? ☐ Yes ☐ No

Are you aware of additional medical history? ☐ Yes ☐ No

(A Confidential report may be sent to the Medical Doctor)

Urinalysis	Specific Gravity	Albumin	Sugar

Details of "Yes" answers. *(Identify them)*

HOME OFFICE SPECIMEN REQUIRED **Mail to: Clinical Reference Laboratory (CRL), 11820 W. 85th St., Lenexa, KS 66214**

MEDICAL EXAMINER:

Please print name _____

Address _____

_____

I certify that I made this examination at: ____ ☐ A.M. ____ ☐ P.M. on the ____ day of _____, _____.

Signature _____

THIS REPORT NOT TO BE GIVEN TO ANY COMPANY REPRESENTATIVE. MAIL THIS REPORT DIRECTLY TO ADMINISTRATIVE OFFICE.