AMICA LIFE INSURANCE COMPANY

P. O. Box 6008
Providence, RI 02940-6008

PART IIA

Proposed Insured ..... (*First name* *Middle initial* *Last name*) | Birth Date: ..... (*Month* *Day* *Year*)

1. a. Name and address of your personal physician? ..... *(If none, so state)*
   b. Date and reason last consulted? .....
   c. What treatment was given or medication prescribed? .....

	Yes	No
2. Have you ever been treated for or ever 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 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?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. *Other than above*, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☐
b. Had a checkup, consultation, illness, injury, surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
d. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐

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

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

9.	Yes	No
a. Have you ever had any disorder of a pregnancy, menstruation, reproductive organs or breasts?	☐	☐
b. To the best of your knowledge and belief are you now pregnant?	☐	☐

I have read the statements and the answers to the above questions and hereby agree that the information is complete and correct to the best of my knowledge and belief and shall be the basis for and a part of any insurance issued.

Dated at.....on.....19..... .....
City-State *Signature of Proposed Insured or Parent or Guardian if a Juvenile*

Witness.....M.D.

MEDICAL EXAMINER'S REPORT

PART III

10a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

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

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

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

12. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. 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)

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	☐	☐

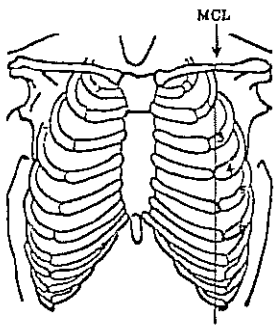
Indicate:

Apex by X

Murmur area by ◌

Point of greatest intensity by O

Transmission by ➧



For comments and your impression?

14. 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 markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias? ☐ Yes ☐ No (b) Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

Details of "Yes" answers. (Identify item.)

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to Home Office? ☐ Yes ☐ No

Send specimen to Home Office if:
(1) There are any abnormalities in specimen examined.
(2) There is a family history of diabetes or a personal history of G. U. Disease or urinary abnormalities.
(3) The blood pressure exceeds 140/90.
(4) The amount applied for is over $200,000 (age 0-45).
(5) The amount applied for is over $100,000 (age 46-59).
(6) The Proposed Insured's age is 60 or over.

Dated at ..... on ..... 19..... ..... Medical Examiner

(City) *(State)* *(Please Print)*

Examiner's P.O. Address .....

APPS PARAMEDICAL
2004 BLAKE RD
SUGAR LAND, TX 77478
(281) 242-8203

Medical Examination Fee

..... *Signature of Medical Examiner*

AUTHORIZATION

Dr.....: You are hereby authorized to give the Medical Department of the AMICA LIFE INSURANCE COMPANY or its reinsurer(s) any and all information regarding my medical history, physical condition and diagnosis.

.....19.....
Date

.....
Signature of Proposed Insured or Parent or Guardian if a Juvenile