ASSURITY LIFE INSURANCE COMPANY
1526 K Street • PO Box 82533
Lincoln, NE 68501-2533
800-276-7619, Ext. 4264 • Fax 402-437-4606

ANSWERS MADE TO THE MEDICAL EXAMINER

In continuation of and forming part of application for insurance

Print full name of
Proposed Insured _____ Born: Month _____ Day _____ Year _____

1. Name of your doctor _____ Date last seen _____
   Address _____ Reason _____
   _____ Findings _____
   Doctor's Phone Number _____ _____
2. Has the proposed Insured ever used any form of tobacco or nicotine-based products? ..... ☐ Yes ☐ No
   If "Yes", when did the proposed Insured last use tobacco or nicotine-based products: Date: _____
3. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60? ..... ☐ Yes ☐ No
   If "Yes", identify family member, disorder, and age at death _____

4. Have you ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following?	Yes	No	DETAILS of "Yes" answers. List questions, circle item. List diagnoses, dates, and durations. Give names, addresses, and phone number of all doctors, hospitals and medical facilities.
a. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous system?.....	☐	☐	
b. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system?....	☐	☐	
c. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder?	☐	☐	
d. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder?	☐	☐	
e. Any disease or disorder of the kidney, bladder or prostate?.....	☐	☐	
f. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?.....	☐	☐	
g. Diabetes, or sugar, albumin or blood in the urine?	☐	☐	
h. Cancer or a tumor or cyst of any kind or enlargement of lymph nodes?.....	☐	☐	
i. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia?.....	☐	☐	
j. Any disease or disorder of the eyes, ears, nose or throat?.....	☐	☐	
k. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse?..	☐	☐	
l. AIDS or the AIDS Related Complex (ARC)?.....	☐	☐	
m. Any other illness or injury requiring blood transfusion or other medical attention?.....	☐	☐	
n. Any special examinations or laboratory tests such as X-rays, or electrocardiograms, blood tests other than AIDS-related blood tests, or urine tests during the past 5 years?.....	☐	☐	

I represent that these statements are true and complete to the best of my knowledge and belief. They are part of my insurance application.

Signed at _____ Signature of Proposed Insured _____
City State

Date _____ Witness _____
Signature of Medical Examiner

☐ M.D.
☐ D.O.
☐ Para Med

MEDICAL EXAMINER'S REPORT

5. Height (In shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen (at Umbilicus) in.	Details of "Yes" answers. (Identify item.)

6. Blood pressure sitting position prior to exercise – (If initial BP exceeds 140/90, record two additional readings.)

Systolic	
Diastolic	

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

8. Heart. Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

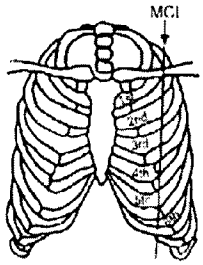
Murmur* ☐ Yes ☐ No Edema ☐ Yes ☐ No

*Describe below

Location _____

Constant ☐
Inconstant ☐
Transmitted ☐
Localized ☐
Systolic ☐
Presystolic ☐
Diastolic ☐
Soft (Gr. 1-2) ☐
Mod. (Gr. 3-4) ☐
Loud (Gr. 5-6) ☐
After Exercise: ☐
Increased ☐
Decreased ☐
Unchanged ☐
Absent ☐

Indicate:
Apex by X
Murmur Area by ○
Point of greatest intensity O
Transmission by ◗



WHAT IS YOUR IMPRESSION?

9. Is there on examination any abnormality of the following:
(Circle applicable items and give details)

	Yes	No
a. Nervous system	☐	☐
b. Musculoskeletal system	☐	☐
c. Eyes, ears, nose, mouth	☐	☐
d. Skin, lymph nodes, thyroid gland	☐	☐
e. Lungs or respiratory system	☐	☐
f. Abdomen	☐	☐
g. Hernia	☐	☐
h. External genitalia	☐	☐
i. Varicose veins or ulcers	☐	☐
j. Other abnormalities	☐	☐

10. Urinalysis: Specific gravity	Albumin	Sugar	Send specimen to laboratory with each exam: Specimen forwarded on: Month _____ Day _____ Year _____

11. How long and how well have you known the applicant?

12. Comments (if any):

13. Examination made at ☐ examiner's office ☐ applicant's home ☐ applicant's office ☐ other _____
on: Month _____ Day _____ Year _____ at _____ a.m. _____ p.m.

Name of agent: _____

Med. Fee: $_____

Other tests requested by agent:

ECG $_____
X-Ray $_____
Dried Blood Profile (Mail kit to laboratory) $_____
Full Blood Profile (Mail kit to laboratory) $_____
Other _____ $_____
Total Fee $_____

By (print name) _____ ☐ M.D. ☐ D.O. ☐ Para Med

Signature _____

Address _____
Street City State ZIP

_____-_____-_____ or _____
Social Security Number Tax ID Number

COMPLETED FORM, ECG TRACINGS AND X-RAY FILMS TO BE MAILED DIRECTLY TO HOME OFFICE