BANKERS LIFE AND CASUALTY COMPANY

600 West Chicago Ave • Chicago, Illinois 60654-2800

APPLICATION (PART II) — STATEMENTS TO MEDICAL EXAMINER

MEDICAL QUESTIONNAIRE — to be completed by the Medical Examiner in his own handwriting.

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 within the past 10 years 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. An immune deficiency disorder, AIDS, AIDS related complex (ARC), AIDS related conditions, or been advised not to donate blood?	☐	☐
m. Any mental or physical disorder not listed above?	☐	☐
3. Do you drink alcoholic beverages?	☐	☐
4. Except as prescribed by a physician, have you ever used:		
a. Heroin, morphine or other narcotic drugs? . .	☐	☐
b. L.S.D., marijuana or any other euphoriant or hallucinogen?	☐	☐
5. Are you now under observation or taking treatment?	☐	☐

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.)

	Yes	No
6. Have you had any change in weight in the past year?	☐	☐
7. **Other than 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?	☐	☐
8. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
9. Have you smoked cigarette(s) in the past year? Show number per day	☐	☐
10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐

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.)

	Yes	No
11. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐
12. a. Have you ever had any disorder of menstruation, pregnancy or of the reproductive organs or breasts?	☐	☐
b. Are you now pregnant?	☐	☐

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

I agree that the above answers are true and complete to the best of my knowledge and belief. I further agree that: (1) they shall be part of my application which shall consist of Parts I and II taken together; and, (2) they shall also become part of any policy that may be issued on the basis of this application.

Dated at _____ County of _____ State of _____

on the _____ day of _____ 20_____

Witness:

_____ M.D.

SPECIALTY? _____

SIGNATURE OF THE PROPOSED INSURED _____

(To be signed in presence of Medical Examiner)

MEDICAL EXAMINER'S REPORT

13a. 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

14. Blood Pressure (Record all readings). If blood pressure is over 140 systolic or 90 diastolic, take 2nd and 3rd readings at intervals.

	At Rest	At Rest	At Rest
Systolic			
Diastolic 5th phase			

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

16. Heart: Is there any:

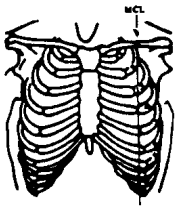
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

If yes to any above, please give details

1st Murmur	2nd Murmur

Location			
Constant	☐	☐	
Inconstant	☐	☐	Indicate
Transmitted	☐	☐	
Localized	☐	☐	Apex by **X**
Systolic	☐	☐	Murmur area
Presystolic	☐	☐	by **O**
Diastolic	☐	☐	
Soft (Gr. 1-2)	☐	☐	Point of
Mod. (Gr. 3-4)	☐	☐	greatest **O**
Loud (Gr. 5-6)	☐	☐	intensity by
After exercise:			Transmission ◗
Increased	☐	☐	by
Absent	☐	☐	
Unchanged	☐	☐	Your diagnosis?
Decreased	☐	☐	



17. 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)?	☐	☐
18. (a) Are there any hernias?	☐	☐
(b) Any hemorrhoids?	☐	☐
19. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

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

	Yes	No
20. Any reason to believe uses or used alcoholic beverages to excess?	☐	☐

21. List any medications being taken. _____

_____

_____

(Identify item.)

Read Carefully

22. Always mail specimen of urine to our designated lab.

Examination of Urine	
Specific Gravity	Reaction
Albumin	Test Used
Sugar	Test Used

Was the specimen to your knowledge passed by the proposed insured? ☐ Yes ☐ No

Details of "Yes" answers.

I certify that I made this examination at _____ ☐ A.M. _____ ☐ P.M. on the _____ day of _____ 20____

Examination made at ☐ my office, ☐ Individual's office, ☐ Individual's home, ☐ Other: _____

Examiner's signature: _____ Examiner's address: _____

Date: _____

_____
NAME OF PROPOSED INSURED

_____
(PLEASE PRINT) NAME OF EXAMINER/PARAMEDICAL FACILITY

_____
TAXPAYER IDENTIFYING NUMBER

_____
ADDRESS OF EXAMINER/PARAMEDICAL FACILITY

$_____
FEE

_____
AUTHORIZED BY AGENT (NAME, NUMBER OFFICE NO.)