THE CINCINNATI LIFE INSURANCE COMPANY

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
cinfin.com ■ 513-870-2000

PART II - MEDICAL
APPLICATION TO THE CINCINNATI LIFE INSURANCE COMPANY

Proposed Insured (first, middle, last)	Birthdate

1. Proposed Insured's Regular Attending Physician (If "None," so state)

Name _____ Address _____

Phone # _____ Date of Last Visit _____ Reason of Last Visit _____

Result of Last Visit _____

	YES	NO
2. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following?		
a. Disorder or disease of eyes, ears, nose, or throat?	☐	☐
b. Psychiatric or mental health disorder or disease such as depression or anxiety?	☐	☐
c. Disorder or disease of the respiratory system such as bronchitis, pleurisy, asthma, emphysema, shortness of breath, tuberculosis, or chronic respiratory disorder?	☐	☐
d. Disorder or disease of the heart, blood vessels or circulatory system such as coronary artery disease, palpitation, high blood pressure, rheumatic fever, heart murmur, or heart attack?	☐	☐
e. Disorder or disease of the stomach, liver, intestines, rectum, pancreas or abdominal organs such as jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, or recurrent indigestion?	☐	☐
f. Disorder or disease of the skeletal system such as deformity, lameness, amputation, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
g. Disorder or disease of the brain or nervous system such as paralysis or stroke, chronic fatigue syndrome,dizziness or fainting, convulsions or frequent headaches?	☐	☐
h. Any sleep disorder such as sleep apnea?	☐	☐
i. Leukemia, anemia or any other blood disorder?	☐	☐
j. Disorder of the skin or lymph glands, cyst, tumor, nodule or cancer?	☐	☐
k. Diabetes, thyroid or any other endocrine disorders?.	☐	☐
l. Diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?.	☐	☐
m. Diagnosed with venereal disease, disorder of breasts or breast implants, prostate or reproductive organs?	☐	☐
n. Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐
3. Are you currently taking prescribed or non-prescribed medications or are you on a prescribed diet?	☐	☐
4. Are you using tobacco products now?	☐	☐
5. Have you ever:		
a. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine or other habit forming drugs, except as prescribed by a physician?	☐	☐
b. Received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non prescribed drugs?	☐	☐
c. Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous?	☐	☐
6. Have you had any change in weight in the past year?	☐	☐
7. Other than above, have you within the past five years:		
a. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
b. Had electrocardiogram, X-ray, other diagnostic test, except those related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐
c. Been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery which was not completed, except those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐

8. Have you, in the past 5 years, requested or received a pension, benefits, or payment because of an injury, sickness, or disability? ..... **YES** ☐ **NO** ☐

9. Family History - To the best of your knowledge and belief:

   a. Has any member of your family been diagnosed or treated by a member of the medical profession for diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or attempted suicide? ..... ☐ ☐

   b.

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters Number Living Number Dead			

10. Females only - To the best of your knowledge and belief:
    Are you now pregnant? ..... ☐ ☐

Details of "Yes" answers. (Identify question number, circle applicable items. Include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.)

I, declare that the above answers relate to the Proposed Insured and are true and complete to the best of my knowledge and belief. These answers are correctly recorded for the purpose of obtaining insurance and any supplemental benefit(s) applied for. I agree that they shall be included as part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ _____ On _____
City State Month Day Year

_____ _____
Signature of Proposed Insured Witness
(Must be Examiner)

THE CINCINNATI LIFE INSURANCE COMPANY

MEDICAL EXAMINER'S REPORT

1. a. 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

2. Blood Pressure (Record ALL readings)

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

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

4. 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)

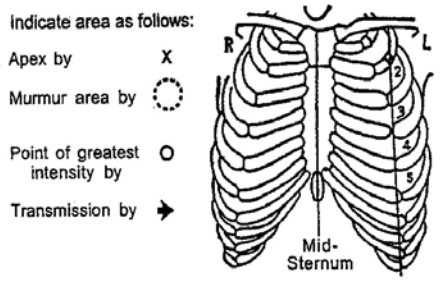
Location

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 ☐ ☐



For comments and your impression

5. 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 (including 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)?	☐	☐
6. a. Are there any hernias?	☐	☐
b. any hemorrhoids?	☐	☐
7. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

	Yes	No
8. a. Are you related to Applicant?	☐	☐
b. Are you associated with the Applicant in any business or financial venture?	☐	☐
9. Have you any reason to believe that he uses or has used alcoholic beverages or drugs to excess?	☐	☐

Details of "Yes" answers (identify item).

10. A specimen is to be forwarded to the Home Office:

Are you forwarding a specimen of proposed Insured's urine? _____

Specific Gravity	Albumin	Sugar

To the Examining Physician:

The Company's normal examination fee is $30.00. If you feel that a reasonably higher charge is warranted, please indicate amount as follows:

Amount of Fee $_____

Your overall estimate of this applicant: ☐ First Class ☐ Good ☐ Fair ☐ Poor

Examined at applicant's residence [ ] on _____ (Mo.) (Day) (Year), at _____ a.m. _____ p.m.
applicant's business [ ]
examiner's office [ ]

Signature of Examiner _____

Please print or type name _____

Examiner's Social Security Number or Taxpayer Identifying Number _____

Examiner's address _____ (Please Print)

At request of _____, Agent Office address _____

Review report carefully for completeness of all sections then mail directly and without exception to the Medical Director, The Cincinnati Life Insurance Company, P.O. Box 145496, Cincinnati, Ohio 45250-5496

Form CLI-6347 (10/16)