Columbus Life Insurance Company

A member of Western & Southern Financial Group

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APPLICATION FOR LIFE INSURANCE – PART 2 – Medical Exam

Proposed Insured _____ S.S.N. _____ Birth Date _____
First Middle Last Month Day Year

1. a) Name & address of your personal physician (if none, so state). _____

b) Date & reason last consulted. _____

c) What treatment was given or medication prescribed? _____

	Yes	No
2. Have you ever been diagnosed with, treated for, hospitalized for or been advised to seek treatment by a member of the medical profession for any of the following:		
a) High blood pressure, high cholesterol or high triglycerides?	☐	☐
b) Heart disease or disorder, heart attack, heart murmur, angina or chest pain, palpitations, irregular heart beat or coronary artery disease?	☐	☐
c) Circulatory system disorder, thrombophlebitis, aneurysm, embolism, peripheral vascular disease or edema?	☐	☐
d) Chronic headaches, carotid artery blockage, seizures, fainting, dizziness, epilepsy, stroke or mini stroke (TIA – transient ischemic attack), paralysis or other nervous system or brain disorder?	☐	☐
e) Any tumor, masses, cysts, cancer, melanoma, pre-cancerous lesion, lymphoma, or disorder of the lymph nodes?	☐	☐
f) Anemia, leukemia, clotting disorder, or any other blood disorder?	☐	☐
g) Diabetes, elevated blood sugar, a disorder of the urinary tract or findings of sugar, protein or blood in the urine?	☐	☐
h) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or bronchitis, spitting up blood or any other disorder of the lungs or respiratory system?	☐	☐
i) Arthritis, gout, fibromyalgia or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
j) Ulcers, colitis, Crohn's disease, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder or pancreas?	☐	☐
k) Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
l) Thyroid, pituitary or other endocrine or glandular disorder?	☐	☐
m) Any nervous, mental, emotional, mood, anxiety or eating disorders, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
n) Any disorder of the eyes, ears, nose or throat?	☐	☐
3. Ever tested positive for exposure to HIV (Human Immunodeficiency Virus) or been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any other immune deficiency disorder?	☐	☐
4. In the past 12 months have you been prescribed any medications other than contraceptives?	☐	☐
5. Within the past five years, have you been treated or examined by a member of the medical profession or been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐
6. Has any immediate family member (parents, sisters or brothers) died as a result of, or been diagnosed with, heart disease prior to age 60?	☐	☐
7. In the past year have you used tobacco or any other product containing nicotine? If **No,** select the answer that best describes tobacco/nicotine product history. ☐ Never Used ☐ Quit: Date (Month/Year) _____	☐	☐

8. Height (in shoes): Ft._____ In. _____ Weight (clothed): Lbs _____ Weight change last 12 months: Loss _____ Gain _____

DETAILS of **Yes** answers. Identify question number:

I have read, or had read to me, the answers in this application before signing below. I declare that the answers are true and complete to my best knowledge and belief, and that there are no exceptions to any answers other than as written.

Signed at (City, State) _____ Date _____

Witness _____ (Examiner)

Proposed Insured _____ (Signature in full of Person Examined)

PART 3 — EXAMINER'S REPORT

Examiners are requested to make a very careful examination of heart and lungs with stethoscope against bared skin.

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

9. a) Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

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

c) Males Only: Measure Abdomen at Umbilicus _____ in

10. Blood Pressure (Record ALL readings.)

Systolic			
Diastolic { 4th phase			
Diastolic { 5th phase			

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

12. 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	☐	☐

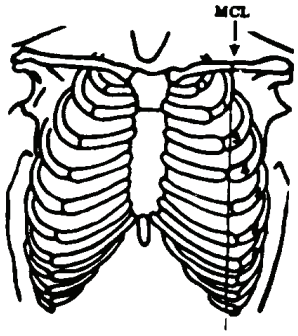
Indicate:

Apex by **X**

Murmur area by ↻

Point of greatest Intensity by **0**

Transmission by →



For comments and your impression?

13. 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 (include scars); lymph nodes; varicose veins or	☐	☐
c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
d) Respiratory system?	☐	☐
e) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
14. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	☐	☐
15. Are you aware of any other abnormalities not otherwise noted?	☐	☐

Urinalysis: Specific Gravity _____

Albumin _____ Sugar _____

	Yes	**No**
Is specimen being sent to lab?	☐	☐
Is blood being drawn?	☐	☐
Is EKG being performed?	☐	☐

SPECIMEN OF URINE REQUIRED WITH ALL EXAMS

Mail urine specimen directly to laboratory as addressed on specimen container.

I certify that I have carefully examined _____ at _____
(city and street address)

on (Date) _____ at _____ a.m. p.m. that the statement of Proposed Insured on other side of this sheet is in
month day year

my handwriting, and is exactly as made by the Proposed Insured to me, and that it was signed by said Proposed Insured in my presence.

_____ _____
(Signature of Examiner) (Address)