EMC National Life Company

PART II

APPLICATION FOR INSURANCE TO EMC NATIONAL LIFE COMPANY

P.O. BOX 9144 • DES MOINES, IOWA 50306-9144

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? _____

2. Have you ever been treated for or ever had any known indication of:	Yes	No
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 gall bladder?	☐	☐
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?	☐	☐
m. An immune deficiency disorder, AIDS, or the AIDS related complex (ARC)?	☐	☐
3. Have you had any change in weight in the past year?	☐	☐
4. 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?	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
6. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
7. 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.)

8. Females only:
   a. Have you ever had any disorder of menstruation, pregnancy or the female organs or breasts? ☐ ☐
   b. To the best of your knowledge and belief are you now pregnant? ☐ ☐

The undersigned, having read the above, Part II agrees that, to the best of his knowledge and belief, the information therein is complete and correct, and shall be the basis for and a part of any insurance issued.

Dated at _____ this _____ day of _____, 20_____.

Witnessed _____ (Examiner) _____ (Signature of Proposed Insured)

LP001 (7-00) THIRD

EMC National Life Company

APPLICATION FOR INSURANCE TO EMC NATIONAL LIFE COMPANY
MEDICAL EXAMINER'S REPORT

9. a. Height (In shoes) ft. in.	Weight (Clothed) lbs.	Males Only: 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

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:

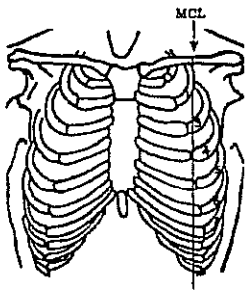
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

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

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

Examined at: ☐ Examiner's Office ☐ Applicant's residence or business

How long have you known Applicant _____

Time of examination _____ A.M. P.M.

Signed _____

PLEASE PRINT

Tax I.D. Number _____

Fee $ _____

Dr. Name _____

Address _____

Mail completed examination to Home Office

EMC
National Life Company
P.O. Box 9144 • Des Moines, Iowa 50306-9144

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

Name _____ Address _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian _____ Name of Proposed Insured _____

Date Signed _____ Address _____

Original — Home Office Copy — Applicant Copy — Agent