Part Two Application for Individual Life Insurance to
Erie Family Life Insurance Company
100 Erie Insurance Place, Erie, PA 16530

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. PLEASE PRINT names and addresses. The proposed insured must sign in the Examiner's presence. Examinations must be made in private.

1. Full name: _____ 2. Date of Birth: _____

3. Is your current weight 15 or more pounds lighter than at any point in the past 12 months? ☐Yes ☐No
If yes, give amount of weight change – ____ lbs. Was the loss due to ☐diet/exercise ☐surgery ☐illness ☐child delivery ☐unknown ☐other: _____

4. In the past 5 years, have you been seen by a physician or a member of the medical profession? ☐Yes ☐No
If yes, please provide the following for the last physician or medical professional seen:
Name of physician/medical professional _____ Date last seen ___/___/___
Address _____ Phone Number _____
Reason for consultation: _____
What tests were done and the results? _____
What recommendations were made? _____

5. Is the physician noted in item #4, your Primary Care Physician (PCP)? ☐Yes ☐No
If not, provide information below for the PCP:
Name _____
Address _____ Phone Number _____

6. Does the proposed insured have a parent or sibling diagnosed with or treated by a member of the medical profession for coronary artery disease, diabetes, kidney disease, stroke, or mini stroke (TIA), melanoma or colon, lung, breast, ovarian, prostate, pancreatic or other cancer, Huntington's disease or an inherited colon polyp syndrome? ☐Yes ☐No
(**If yes, complete details below for parents and siblings.**)

	Health Condition and Date of Onset (Heart Attack, Stroke, Cancer, etc.)		Current Age (If Alive)	Age at Death (If Deceased)	Cause of Death (If Deceased)
Father	Date:				
Mother	Date:				
Siblings	Date:				
	Date:				
	Date:				

7. Have you ever smoked cigarettes (including E cigarettes)? ☐Yes ☐No
If yes, please complete the following: ☐ current smoker ☐ past smoker **Date of last cigarette use:** ____/___/____

8. Have you ever used tobacco or nicotine dispensing products in any form other than cigarettes, including, but not limited to, smokeless tobacco, pipe, cigar and hookah smoking or nicotine gum/patches? ☐Yes ☐No
If yes, please complete below:

Type of Tobacco/Nicotine Used	Frequency	Date Last Used	Type of Tobacco/Nicotine Used	Frequency	Date Last Used
_____	_____	___/___/___	_____	_____	___/___/___
_____	_____	___/___/___	_____	_____	___/___/___

Give complete information regarding "Yes" answers to questions 9 through 16 under "Details" below. Specify conditions, treatments, severity, date, duration, frequency of attacks, aftereffects, test results, and name and address of each doctor and of each hospital seen. IDENTIFY QUESTION NUMBER WHEN PROVIDING DETAILS FOR ANSWERS **YES NO**

9. Have you **ever been** diagnosed with alcoholism, alcohol or substance abuse or dependence or been advised to reduce, discontinue or seek treatment for the use of alcohol or drugs by a member of the medical profession or received treatment, advice or counseling from any physician, counselor or other medical professional or joined a support group due to alcohol or drug use? ☐ ☐

10. Have you **ever used** any controlled substance such as cocaine, heroin, narcotics, amphetamines, barbiturates, sedatives, hallucinogens, or marijuana without a medical prescription? ☐ ☐

11. **In the past 5 years,** have you had a diagnostic test such as an EKG, echocardiogram, MRI or CT scan, sleep study, blood testing or other diagnostic testing or have you been advised to have a medical test or procedure that has not been done? (If yes, include reason for and date and result of test/procedure) ☐ ☐

Details to yes questions:
Question Number: Details, including date and physician:

Any changes or corrections to questions or details should be initialed by the proposed insured.

Part Two Application Continuation

	YES	NO
12. Have you **ever been** diagnosed with, treated, or tested positive for, or been given medical advice by a member of the medical profession for:		
a. dizziness, severe headaches, loss of consciousness, memory loss, paralysis, stroke or mini stroke, epilepsy or seizures, multiple sclerosis, or any brain or nervous system disease or disorder?	☐	☐
b. depression, anxiety, bipolar disorder, eating disorder, suicide attempt or other mental or emotional illness?	☐	☐
c. any breathing disorder including asthma, chronic obstructive pulmonary disease (COPD), sleep apnea or any disease or disorder of the lungs or respiratory system?	☐	☐
d. hepatitis, cirrhosis, ulcerative colitis, Crohn's disease, pancreatitis, ulcer or any other disease or disorder of the stomach, esophagus, colon, intestines, liver, glands or digestive system?	☐	☐
e. high blood pressure, chest pain, heart attack, heart murmur, congestive heart failure, irregular heartbeat, anemia, or any disease or disorder of the heart, blood, or circulatory system?	☐	☐
f. diabetes, impaired fasting glucose, gestational diabetes, bladder or kidney disease or disorder or sugar, protein, albumin or blood in the urine?	☐	☐
g. arthritis, lupus or other connective tissue disease, any physical deformity or defect or any disease or disorder of the back, bones, joints, skin, lymph nodes or muscles?	☐	☐
h. cancer including leukemia and melanoma or any tumor, polyp or atypical mole?	☐	☐
i. urethritis, chlamydia, HPV, genital warts or any sexually transmitted disease?	☐	☐
j. any tumor or disease of the breast or genital organs, menstrual irregularity or complications of pregnancy or any prostate disorder?	☐	☐
k. any impairment of hearing or sight (except for the need for corrective lenses)?	☐	☐
l. immune deficiency disease or disorder, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for anti-bodies to the AIDS (HIV) virus (except by a home testing kit)?	☐	☐
13. **Other than as indicated in an answer to a previous question**, have you **in the past 5 years** been in a clinic, hospital or other medical facility for treatment, observation, evaluation or operation?	☐	☐
14. **In the past 5 years,** have you been advised by a member of the medical profession to have or contemplated having a surgical procedure that has not been done?	☐	☐
15. **In the past 5 years,** have you consulted or been treated or examined by a member of the medical profession		
a. **not named in an answer to a previous question**? or,	☐	☐
b. for any cause **not recorded in an answer to a previous question**?	☐	☐
16. **Other than those already disclosed**, are you receiving treatment or taking prescription or non prescription medications or supplements of any kind?	☐	☐
17. (Females only) Are you now pregnant? If yes, due date_____	☐	☐

Details to yes questions:

Question Number: Details, including date and physician:

Any changes or corrections to questions or details should be initialed by the proposed insured. If additional space is required, please use the attached application continuation sheet and ensure the question numbers are captured along with the applicant's signature and date at the bottom of the form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I represent that I have read (or have had read to me) and understood all of the above questions and the answers to them are true and complete to the best of my knowledge and belief and correctly recorded with no exceptions and they shall form a part of my pending applications(s) with Erie Family Life Insurance Company.

_____

Signature of Proposed Insured

Witness_____ Date of Exam_____

Signature of Examiner

Part Three Examiner's Report

	YES	NO
1. Height: **(No Shoes)** _____ft. _____ in. Did you measure?	☐	☐
Weight without coat: _____lbs. Did you weigh?	☐	☐
2. Measurements (Males Only) Chest: forced inspiration _____ inches forced expiration _____ inches Waist:_____inches		
3. a. Pulse (Seated):_____ b. Is pulse regular?	☐	☐
If not, give the number of irregularities per minute _____		
4. Blood Pressure. **Please record all readings.** With history of hypertension or if first reading is over 140 systolic or over 90 diastolic, take two additional readings at 2 minute intervals. **First Reading** **All Subsequent Readings:** **Systolic** ..... **Diastolic** ..... **What size blood pressure cuff was used?** ☐ **Regular** ☐ **Large**		
5. a. Does proposed insured use any device to aid in locomotion?	☐	☐
b. Does proposed insured seem alert, oriented to time and place?	☐	☐
6. Is proposed insured able to recall medical history without hesitation or assistance?	☐	☐
7. Is proposed insured lame, maimed or deformed?	☐	☐
8. a. Does proposed insured appear older than stated? If "yes," give apparent age_____	☐	☐
b. Does his/her appearance indicate good health?	☐	☐
9. Were the circumstances under which you completed the examination satisfactory?	☐	☐
10. Are you in any way related to proposed insured or agent? Which one and how related?	☐	☐
11. Are you aware of anything about the health, habits, environment, or mode of life of proposed insured which might unfavorably affect his/her insurability?	☐	☐
12. How long and how well have you known proposed insured?_____		

URINALYSIS MUST BE COMPLETED ON EVERY EXAMINATION

Specific gravity? _____ Reaction? _____
Albumin? _____ Test Used? _____
Sugar? _____ Test Used? _____

SEND ALL SPECIMENS TO OUR APPROVED LABORATORY

Details to questions 5-12:

I certify that I have carefully examined _____ and that the examination was made in private at :

☐ the examiner's office ☐ residence of proposed insured ☐ place of business of proposed insured

Date of exam_____ Time_____ ☐ AM ☐ PM

Examined at : _____ By:_____

City State Examiner Signature

THIS EXAMINATION MUST BEAR THE DATE WHEN ACTUALLY MADE & UNDER NO CIRCUMSTANCES ANY OTHER.

Continuation of details to questions on Part Two Application to Erie Family Life Insurance Company on the life of: _____.

Question Number:	Details, including date and physician:

Any changes or corrections to questions or details should be initialed by the proposed insured.

_____ _____

Signature of Proposed Insured Date