Paramedical Supplement to Life Insurance Application

Fidelity & Guaranty Life Insurance Company
Home Office: Des Moines, IA • Administrative Office: P.O. Box 81497; Lincoln, NE 68501-81497 • Phone: 888.513.8797

Name of Interviewer (First, M.I., Last)	Does the Interviewer know the proposed Insured? ❑ Yes ❑ No	If "Yes", how does the Interviewer know the proposed Insured?
Name of Examiner If different From Interviewer (First, M.I., Last)	Does the Medical Examiner know the proposed Insured? ❑ Yes ❑ No	If "Yes", how does the Medical Examiner know the proposed Insured?
Information Source: ❑ Proposed Insured ❑ Other Name:_____ Relationship to proposed Insured: _____ Is proposed Insured unable to provide the information? ❑ Yes ❑ No If "Yes", please provide details in Additional Information section.		
Date of Interview	Time of Interview ❑ AM ❑ PM	

PROPOSED INSURED

Name (First, M.I., Last)				
Home Address		City	State	Zip
Social Security Number/Tax ID Number		Date of Birth	Gender ❑ Male ❑ Female	
Driver's License Number	DL Issue State	Other Identification Number (*If Driver's License not used*) _____ Type of ID ❑ State ID ❑ Passport ❑ Military ID ❑ Permanent Resident Card ❑ Other _____	ID Issue State and Country	

PRIMARY MEDICAL PROVIDER INFORMATION

❑ ***Proposed Insured does not have a primary medical provider.***

Medical Provider Name			Medical Provider Phone Number
Medical Provider Address	City	State	Zip
Date Last Seen	Reason and Results of Last Visit		

MEDICAL HISTORY QUESTIONS

1.	Has the proposed Insured ever been diagnosed, received treatment, or been advised to seek treatment by a member of the medical profession regarding:			
	a)	Any disorder of the heart or blood vessels including but not limited to coronary artery disease, heart attack, heart failure, chest pain, irregular heartbeat, valvular heart disease, congenital heart disease or defect, heart murmur, high blood pressure, or high cholesterol?	❑ Yes	❑ No
	b)	Any disorder of the circulatory system including but not limited to stroke, transient ischemic attack (TIA), aneurysm, carotid artery disease, or peripheral vascular disease?	❑ Yes	❑ No
	c)	Any disorder of the lungs or respiratory system including but not limited to asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, tuberculosis, or sleep apnea?	❑ Yes	❑ No
	d)	Any disorder of the immune system or endocrine system including but not limited to diabetes, anemia, blood disorder, or thyroid disorder (except those related to the Human Immunodeficiency Virus (AIDS Virus))?	❑ Yes	❑ No
	e)	Cancer, tumors, polyps, or cysts?	❑ Yes	❑ No
	f)	Any psychiatric or mental health disorder including but not limited to anxiety, depression, bipolar disorder, schizophrenia, or post-traumatic stress disorder?	❑ Yes	❑ No

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MEDICAL HISTORY QUESTIONS (*continued*)

	g)	Any neurological or brain disorder including but not limited to epilepsy, seizures, paralysis, multiple sclerosis, Alzheimer's, Parkinson's disease, dementia, or chronic headaches?	❑ Yes	❑ No
	h)	Lupus or other connective tissue disease; any autoimmune disorder?	❑ Yes	❑ No
	i)	Any disease or disorder of the stomach, liver, intestines/colon, or pancreas including but not limited to ulcer, hepatitis, Crohn's disease, or ulcerative colitis?	❑ Yes	❑ No
	j)	Any disease or disorder of the kidneys, bladder or urinary system; prostate, breasts, or reproductive system?	❑ Yes	❑ No
	k)	Any disease or disorder of the muscle, bones, spine, or joints including but not limited to arthritis, fibromyalgia, or chronic pain?	❑ Yes	❑ No
	l)	Any disease or disorder of the skin, eyes, ears, nose or throat?	❑ Yes	❑ No
2.		Has the proposed Insured ever been diagnosed or treated by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	❑ Yes	❑ No
3.		Other than previously indicated, in the past 5 years, has the proposed Insured:		
	a)	Been treated or diagnosed by a member of the medical profession with any mental or physical disorder?	❑ Yes	❑ No
	b)	Had any electrocardiogram (EKG), x-ray, laboratory test, treatment, or procedure? (*Excludes tests related to the Human Immunodeficiency Virus (HIV)).*	❑ Yes	❑ No
	c)	Been hospitalized or had any surgery or procedure?	❑ Yes	❑ No
	d)	Been advised by a member of the medical profession to have any diagnostic test, treatment, surgery or other procedure which has not been performed? (*Excludes tests related to the Human Immunodeficiency Virus (HIV)*.	❑ Yes	❑ No
	e)	With or without the recommendation, prescription or knowledge of a medical professional have you undergone any predictive, screening or diagnostic testing including and not limited to genetic or self-administered testing which may lead to a personal health assessment? (Do not answer if you are a resident of DE, NV, or OR. Applicants residing in MA are not required to answer this question. For MA residents only, failure to answer the question may result in an increased rate or denial of coverage.)	❑ Yes	❑ No
4.		Has a natural parent or sibling of the proposed Insured died prior to age 60 from coronary artery disease or cancer; or ever been diagnosed or treated by a member of the medical profession for any hereditary disease such as Huntington's disease or polycystic kidney disease?	❑ Yes	❑ No
5.		Has the proposed Insured ever used tobacco or nicotine substitute in any form including but not limited to cigarettes, cigars, pipes, chewing tobacco, snuff, electronic cigarettes, vaporizer (vape), nicotine gum or patches? *If "Yes":* Form(s) used _____ Frequency of use _____ Date(s) last used _____	❑ Yes	❑ No

ADDITIONAL INFORMATION *Please use space below to provide details to any "Yes" answers.*

Question	Detail

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MEDICAL HISTORY QUESTIONS (*continued*)

6.	Other than previously indicated, specify all medications the proposed Insured is currently taking, or has taken in the past 5 years, including prescription, non-prescription, or herbal remedies.

Medication Name	Condition/Disorder	Dosage	Frequency	Beginning Date

CERTIFICATION

I have read the questions and answers on this Paramedical Supplement to Life Insurance Application and certify that the statements made in this application are, to the best of my knowledge and belief: complete; true; and correctly recorded and are subject to the applicable **FRAUD NOTICE** in the life insurance application. **I agree that: a copy of this Paramedical Supplement to Life Insurance Application will form a part of any life insurance contract issued; and that no agent or medical examiner can pass on insurability or modify any life insurance contract issued by Fidelity & Guaranty Life Insurance Company.**

I certify, under penalties of perjury, that I am the person identified in this Paramedical Supplement to Life Insurance Application, I am a U.S. Citizen or U.S. person, and the Social Security Number/Taxpayer Identification Number is correct. I understand that federal law requires all financial institutions to obtain identity information in order to verify my identity and I authorized its use for this purpose. This information includes, but is not limited to, name, residential address, date of birth, Social Security Number/Taxpayer Identification Number, and any other information necessary to sufficiently verify my identity. I understand that failure to provide this information could result in the application being rejected. Third party sources may be used to verify the information provided.

Signed at (City and State)	Date
Witness (Medical Examiner)	
Signature of proposed Insured if Age 15 or Older	
Signature of Parent or Legal Guardian if proposed Insured is 18 or younger	

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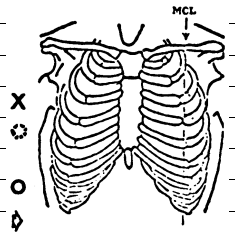
MEDICAL EXAMINER'S REPORT

				Males Only:		
14.	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? ❑ Y ❑ N		Did you measure? ❑ Y ❑ N		
	c)	Is appearance unhealthy or older than stated age? ❑ Y ❑ N				

15.	Blood Pressure:	1st Reading	2nd Reading	3rd Reading
	Systolic			
	Diastolic 5th Phase			
16.	Pulse (Answer All columns):	At Rest	After Exercise	3 Minutes Later
	Rate			
	Irregularities per min.			
17.	Heart: Is there any:			
	Enlargement:	❑ Y ❑ N	Dyspnea:	❑ Y ❑ N
	Murmur(s):	❑ Y ❑ N	Edema:	❑ Y ❑ N

	Murmur 1	Murmur 2	
Murmur location			Indicate:
Transmitted	❑	❑	
Localized	❑	❑	
Constant	❑	❑	
Inconstant	❑	❑	Apex by: X
Systolic	❑	❑	Murmur area by: ○
Diastolic	❑	❑	Point of greatest
Presystolic	❑	❑	intensity by: o
Soft (Gr. 1-2)	❑	❑	Transmission by: ◊
Mod. (Gr. 3-4)	❑	❑	
Loud (Gr. 5-6)	❑	❑	In your opinion, is murmur organic or functional?
After Exercise:			_____
Increased	❑	❑	
Unchanged	❑	❑	If organic, your diagnosis: _____
Decreased	❑	❑	_____



18.	Is there, on examination, any abnormality of the following *(circle applicable item and give details).*		
	a)	Eyes, ears, nose, mouth, pharynx? *(If vision or hearing is markedly impaired, indicate degree and correction)*	❑ Y ❑ N
	b)	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	❑ Y ❑ N
	c)	Nervous system (includes reflexes, gait, paralysis)?	❑ Y ❑ N
	d)	Respiratory system?	❑ Y ❑ N
	e)	Abdomen (include scars)?	❑ Y ❑ N
	f)	Genitourinary system (include prostate)?	❑ Y ❑ N
	g)	Endocrine system (include spine, joints, amputation, deformities)?	❑ Y ❑ N
	h)	Musculoskeletal system (include spine, joints, amputation, deformities)?	❑ Y ❑ N
19.	a)	Are there any hernias? ❑ Y ❑ N b) Any hemorrhoids?	❑ Y ❑ N
20.	Are you aware of any additional medical history?		❑ Y ❑ N

(A confidential report may be forwarded to the medical director)

Record any additional information here: it will be considered strictly confidential. Anything regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated:

Name of person who requested you make this examination:

Place Examined: ❑ Your Office ❑ Proposed Insured's ❑ Home or ❑Office

Date Examined: Time: am/pm

Signature of Medical Examiner		
Address	City	ZIP
HOME OFFICE USE ONLY:	Fee Paid $	