Statements made to MEDICAL EXAMINER in continuation of and forming part of the application for insurance in the

Federal Life Insurance Company (Mutual)

3750 WEST DEERFIELD ROAD • RIVERWOODS, ILLINOIS 60015-3598

PART II

1. (a) Full Name? (Please Print)	(b) Date of Birth?	(c) Occupation?	(d) Agency?

2. So far as you know and believe have you ever had:	Yes or No?	What? When? Duration? Results?	Doctors and Addresses?
a. Tuberculosis, asthma, any allergy, pleurisy, chronic cough, disease of lungs or respiratory disorder?			
b. Paralysis, convulsions, headaches, dizziness, mental disorder, disease or injury of brain or nervous system?			
c. Elevated blood pressure, chest pain, or disease of the heart or circulatory system?			
d. Disease of urinary system (kidneys, ureters, bladder, prostate), or sugar, blood or albumin in urine?			
e. Disease of digestive system (stomach, gall bladder, liver, intestines, rectum)?			
f. Hernia, varicose veins, arthritis, syphilis, diabetes, cancer, goitre, neuritis, sacro-iliac or bone disorder?			
g. An injury to or disease of eyes or ears, or an impairment of sight or hearing?			
h. Any other ailment, injury or operation?			
i. An electrocardiogram, X-ray, blood study or other special diagnostic test?			
3. Have you consulted a physician within five years for checkup, or illness, injury, or impairment not listed above?			
4. So far as you know and believe, have you now any ailment, disease or disorder?			
5. Has your weight changed in the past year? Gain? lbs. Loss? lbs. Why?			
6. Do you now or have you within the past twelve months smoked cigarettes?			
7. Have you: a. Used, or been arrested for the use or possession of any narcotic, stimulant, sedative or hallucinogenic drug?			
b. Sought advice or treatment for, or been arrested for the use of alcohol or drugs?			
8. Have you ever been under observation, care or treatment in any hospital or similar institution?			
9. Have you ever been declined, postponed, rated up, ridered or refused renewal for live or health insurance?			
10. Have you ever applied to any government or insurance organization for payments on account of disability?			
11. To the best of your knowledge has any member of your family died of, or ever had: (Give age and relationship) a. Heart trouble, high blood pressure, cancer?			
b. Tuberculosis, diabetes, mental disorder?			
12. IF FEMALE: To the best of your knowledge have you had a disease of breasts, uterus or ovaries?			

I hereby declare that I have read the statements and answers to the above questions, that they are complete and true to the best of my knowledge and belief and agree that this application consisting of Part I and this Part II, shall form the basis for and be a part of any policy of insurance issued, and that no information acquired by any representative of the Company shall bind the Company unless it is set out in writing in this application.

Dated at _____ this _____ day of _____ 19_____.

Witness _____ M.D. _____

Signature of Medical Examiner — Signature of Proposed Insured

1. a. HAVE YOU ATTENDED PROPOSED INSURED PROFESSIONALLY?_____ b. ARE YOU RELATED?_____ APPRECIATE DETAILS.

2. a. Height_____ft._____in. b. Weight_____lbs. c. Did you { Weigh him?_____ / Measure him?_____ } d. Girth { Chest forced expiration_____inches / Chest full inspiration_____inches / Abdomen at umbilicus_____inches }

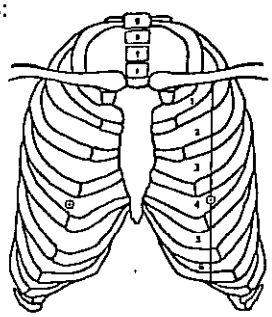
	Yes or No?
3. Is there any evidence of:	
a. Poor health, poor environment, or alcoholic excesses?	
b. Mental or physical defects or scars?	
c. Disorder of MOUTH, THROAT, EARS, or impairment of HEARING?	
d. Disease of EYES or impairment of VISION?	
e. Disorder of THYROID or LYMPH NODES?	
f. Past or present disorder of LUNGS?	
g. ABDOMINAL tenderness or masses?	
h. HERNIA? (Truss?)	
i. Disorder of BONES, JOINTS, or SKIN?	
j. VARICOSE VEINS or VENEREAL DISEASE?	
k. Tremors or abnormality of pupils or deep reflexes?	
4. Is there any evidence of CARDIAC ENLARGEMENT? Slight ☐ Moderate ☐ Marked ☐	
5. Is there any evidence of ARTERIOSCLEROSIS? Slight ☐ Moderate ☐ Advanced ☐	

DESCRIBE FULLY ANY ABNORMALITIES NOTED

6. a. is there a HEART MURMUR? Yes ☐ No ☐
   b. It is Constant ☐ Inconstant ☐
   c. It is Systolic ☐ Presystolic ☐ Diastolic ☐
   d. It is Faint ☐ Moderate ☐ Loud ☐
   e. It is not Transmitted ☐ Is Transmitted ☐ to_____
7. BLOOD PRESSURE: Syst._____ Diast. (V phase)_____
   If systolic over 140 or diastolic over 90, recheck at end of examination. Record all readings. Any treatment?
8. a. PULSE RATE per min.)_____
   b. IRREGULARITIES (# per min.)_____
9. EXCEPT WHEN CLINICALLY CONTRAINDICATED, perform EXERCISE TEST of 25 to 50 vigorous hops whenever:
   A history of cardio vascular disease is obtained, or
   The pulse is irregular or the rate is over 90, or
   A heart murmur is found.

a. PULSE	IMMED. AFTER EXERCISE	3 MINUTES LATER
Rate per minute		
Irregularities per minute		

   b. After exercise HEART MURMUR is:
   Accentuated ☐ Abolished ☐
   Unaffected ☐
   c. Show location of murmur.
   Apex by X
   Area of murmur by outline ◌
   Point of greatest intensity O
   Transmission →



   d. Any chest pain or dyspnea?_____
   e. Your impressions of murmur?_____

10. URINE: to be voided in your presence or next room.
    Specific gravity? _____Albumin?_____Sugar?_____
    Send specimen to Home Office if:
    a. Albumin or sugar in history or findings.
    b. History of any urinary tract disorder.
    c. History or presence of elevated blood pressure.
    d. Age over 55 or amount $100,000 or over.
    e. Diabetes in the immediate family.
    Are you sending specimen to Home Office?_____

I certify that I have carefully examined_____ of_____
(print full name) (address)

in private at ☐ my office ☐ his place of business ☐ his home this_____day of_____19_____at_____o'clock ☐ A.M. ☐ P.M.

If not regular Company examiner, please advise:
1. Medical school where graduated_____
2. Date of graduation_____
3. Names of companies for whome you examine_____

Examiner's Signature_____M.D.

Address_____

PLEASE DO NOT DISCUSS YOUR FINDINGS WITH THE PROPOSED INSURED.
IF YOU PREFER, CONFIDENTIAL INFORMATION MAY BE REPORTED DIRECTLY TO THE HOME OFFICE BY SEPARATE LETTER.

MEDICAL EXAMINER MUST COMPLETE THIS VOUCHER SO THAT PROPER CREDIT FOR THE EXAMINATION WILL BE MADE.

DO NOT DETACH

APPLICANT (Please Print)			AGENCY (Please Print)		
NAME OF PARA MEDICAL FACILITY:			EXAMINER (Please Print) M.D.		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

MEDICAL FEE VOUCHER: FEDERAL LIFE INSURANCE COMPANY (MUTUAL)

Federal Life Insurance Company (Mutual)

3750 West Deerfield Road • Riverwoods, Illinois 60015

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 counselling, 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 Insurers 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: _____

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 | Date Signed

_____ _____

Name of Proposed Insured (Print) | Address

_____

City, State, and Zip Code