Any person who, with intent to injure, defraud or deceive any insurance company, submits a statement of claim or application containing false, incomplete or misleading information, may be subject to criminal and/or civil penalties.

Medical Part II of Application to
FEDERATED LIFE INSURANCE COMPANY
121 East Park Square, P.O. Box 328, Owatonna, Minnesota 55060

Amount Applied for: $ ____________________ Pending or Policy No. (if known) ____________

Purpose: ☐ New application ☐ Rate reconsideration ☐ Reinstatement ☐ ________________

1. PROPOSED INSURED ____ Date of birth ____________
First Middle Last

2. a. Full name and address of personal physician: ____

b. Date last consulted:_______________ Reason:____

3. Have you within the last 10 years had or been treated for: (Circle items which apply.)
   a. disease of glands, skin, joints or bones; thyroid disorder, arthritis, rheumatism, gout, back injury or discomfort? . . ☐ No ☐ Yes
   b. dizzy or fainting spells, epilepsy, paralysis, nervous or mental disorder? . . . . ☐ No ☐ Yes
   c. coughing up blood, tuberculosis, asthma, bronchitis, pleurisy, pneumonia, or lung abscess? . . . . . . ☐ No ☐ Yes
   d. high blood pressure, high cholesterol level, or other disorder of blood or blood vessels? . . . . . . ☐ No ☐ Yes
   e. pain or discomfort in chest, rheumatic fever, heart murmur, or other heart disorder? . . . . . . ☐ No ☐ Yes
   f. disorder of stomach, liver, gallbladder, intestines, rectum; ulcer, appendicitis, colitis, gastritis, or hernia?. . . . ☐ No ☐ Yes
   g. syphilis, kidney stone or colic, or any other disorder of kidneys, bladder, or reproductive organs? . . . . ☐ No ☐ Yes
   h. sugar, albumin, or any other abnormality of urine? . . . . ☐ No ☐ Yes
   i. diabetes, tumor, leukemia, or cancer? . . . . ☐ No ☐ Yes
   j. disorder of eyes, ears, nose, or throat? . . . . ☐ No ☐ Yes
4. Other than the above, have you within the last 5 years:
   a. had any illness, disease, or injury? . . . . ☐ No ☐ Yes
   b. consulted, been examined, or treated by any physician or practitioner? . . . . . . ☐ No ☐ Yes
   c. had a checkup or routine physical examination? . . . . ☐ No ☐ Yes
   d. had an electrocardiogram, x-ray, laboratory test or study? . . . . ☐ No ☐ Yes
5. Are you now taking treatment or medication for any condition or disease? . . . . . . ☐ No ☐ Yes
6. Have you had any change in weight in the past year? If yes, ________lbs. ☐ gained ☐ lost . . . . . . ☐ No ☐ Yes
7. Have you any deformity, amputation, or any physical disability? . . . . ☐ No ☐ Yes
8. a. Have you served with the Armed Forces? . . . . ☐ No ☐ Yes
   b. Were you deferred, rejected, or discharged for a physical or medical reason?. . . . . . ☐ No ☐ Yes
9. In your immediate family, has there been high blood pressure, stroke, heart or kidney disease, diabetes, mental or nervous disorder, or suicide? . . . . ☐ No ☐ Yes
10. a. Are you a cigarette smoker? (If yes, indicate amount per day: ______________) . . . . . . ☐ No ☐ Yes
    b. Have you been a cigarette smoker and quit? (If yes, when did you quit? __________________) . . . . ☐ No ☐ Yes
    c. Do you use any other form of tobacco? (If yes, what form(s) do you use? __________________) . . . . ☐ No ☐ Yes
11. If applicable,
    a. within the last 10 years have you had any menstrual disturbance or complicated pregnancy? . . . . . . ☐ No ☐ Yes
    b. are you now pregnant? (If yes, date of expected delivery: ____________________) . . . . . . ☐ No ☐ Yes
12. If applicable:
    a. Do you have an annual breast exam/PAP test? . . . . ☐ No ☐ Yes
    b. If not, state month/year last breast exam was complete: ____________

(List details to all "yes" answers under item 13 on reverse.)

DO NOT WRITE IN THIS SPACE

13. **DETAILS IN CONNECTION WITH ALL QUESTIONS ANSWERED "YES" ON REVERSE:**

Question	Date	Include nature of illness or injury, duration, treatment, results, name and address of doctors, hospitals or clinics involved.

14.

Family History	Age if Living	State of Health	Age at Death	Cause of Death	Family History	Age if Living	State of Health	Age at Death	Cause of Death
Father					Mother				
Brothers ____ Living ____ Dead					Sisters ____ Living ____ Dead				

I hereby declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief. In any legal procedure to rescind or recover within the contestable period, the Company will assume the following: If the Company alleges a misrepresentation in respect to question 2a or b, 4a, b, c, or d, or 5, and I or any claimant try to prevent full disclosure and proof of the nature of the medical impairment involved, such misrepresentation will be presumed material to the risk.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, Inc., insurance or reinsurance company, employer or other institution, organization or person to release any and all medical data about me or my minor children to Federated Life Insurance Company, its reinsurers, or legal representatives. Medical means all data in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my minor children.

I agree that this authorization is valid for two years from the date shown below and that a copy of this form will be valid as the original.

READ THE ABOVE PARAGRAPHS CAREFULLY BEFORE SIGNING

Signed in
my presence: ______________________________ M.D. ______________________________
Medical Examiner Signature of **PROPOSED INSURED** in full

Date ______________________ ______________________________
Name of Representative who requested this exam

(Sign with durable ink for permanence of record)

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DO NOT WRITE IN THIS SPACE

PART III | **MEDICAL EXAMINER'S REPORT**

15. a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs.	in.	in.	in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

16. Blood Pressure (Record ALL readings)	1st	2nd	3rd
Systolic			
Diastolic			

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

18a. Heart: Is there any:

Enlargement? ☐ Yes ☐ No Dyspnea? ☐ Yes ☐ No

Murmur(s)? ☐ Yes ☐ No Edema? ☐ Yes ☐ No

(describe below – if more than one murmur, 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	☐	☐

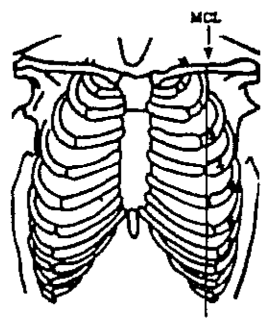
Indicate:

Apex by X

Murmur Area by O

Point of greatest intensity by O

Transmission by ➧



For comments and your impression.

18b. Respiratory System: Are there any: Yes No

a. Abnormalities? ☐ ☐

b. If Yes, please describe:

19. Are there, upon examination, any abnormalities of the following:
(Circle applicable items and give details.) Yes No

a. Eyes, ears, nose, mouth, pharynx, skin? ☐ ☐
(If vision or hearing markedly impaired, indicate degree and correction.)

b. Lymph nodes? ☐ ☐

c. Nervous system (Include reflexes, gait, paralysis)? ☐ ☐

d. Abdomen (Include scars)? ☐ ☐

e. Musculoskeletal system (Include spine, joints, amputations, deformities)? ☐ ☐

Details of "Yes" answers and any additional medical history or findings.

(See Reserve Side)

VOUCHER FOR PAYMENT OF EXAMINATION FEE

Fees for Medical Examinations are paid monthly by check from the Home Office. DO NOT ACCEPT PAYMENT FROM ANY OTHER SOURCE.

This voucher will be returned to you with the Company's check and will serve as a record of the fee paid. Record this examination in your day-book and if payment is not received within 60 days please notify the Medical Department.

	Yes	No	Details of "Yes" answers and any additional medical history or findings.
20. Upon questioning, are there:			
a. Any hernias?	☐	☐	
b. Any hemorrhoids?	☐	☐	
21. Are you this client's regular physician?	☐	☐	
Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐	

22. Urinalysis: (Always required) Specific Gravity	Albumin	Sugar
Is additional specimen being sent to H.O. Ref. Lab (Kansas)*? ☐ Yes ☐ No		

*Send specimen to Home Office Reference Laboratory, Shawnee Mission, KS if:
(1) Amount applied for is $100,000 or over
(2) There is previous or current urinary abnormality, diabetes, or elevated blood pressure.
(3) Client is currently pregnant.

I certify that the above is a record of a careful examination of the Proposed Insured and that I faithfully recorded the answers on Part II

of the application before the signature of the Proposed Insured was affixed thereto. Examination made at ____________ A.M. / P.M.

on (Date) ____________________

at ☐ My office ☐ Proposed Insured's Home ☐ Proposed Insured's place of business in:

City and State ______________________________

Where graduated ______________________________

Date of graduation ____________________

Signature of Examiner ______________________________
☐ Physician ☐ Paramedic

Office Address: Street & No. ______________________________

City, State, & Zip Code ______________________________

Review report carefully for completeness of all sections, then mail directly, without exception, to the Medical Director at the Home Office.

COMPLETE VOUCHER BELOW – DO NOT DETACH.

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PLEASE PRINT – DO NOT DETACH

Client's Name ______________________________
Address ______________________________
City and State
Date of examination ______________________________

____
Name of Marketing Representative who requested you to make this examination

Examiner's Name ______________________________
Address ______________________________
____
☐ Paramedic ☐ Physician

FEDERATED LIFE INSURANCE COMPANY
121 East Park Square
P.O. Box 328
OWATONNA, MINNESOTA 55060