Fidelity Life Association, A Legal Reserve Life Insurance Company
P.O. Box 5030
Des Plaines, IL 60017
(630) 522-0392

FIDELITYLIFE
Established 1896

File Number:_____

Medical Questionnaire

Questions apply to the Proposed Insured named below. Use the Details Section below and on Page 2 as needed to explain "Yes" answers.

1. **Proposed Insured:** Full Name (Last, First, MI)	Birthdate	Social Security Number

Purpose of this examination: ☐ New Application ☐ Change of existing policy ☐ Reinstatement of lapsed policy

2. **Have you, within the last 10 years, been treated by a physician for, or been diagnosed as having:**
Irregular Heart Beat (Arrhythmia), Blockage or Narrowing of the Arteries or Stroke or Congestive Heart Failure (CHF), Atherosclerosis, Coronary Artery Disease (CAD), Malignant Neoplasm, Lymphoma, Melanoma or Leukemia, Liver Disease other than Hepatitis, Memory Loss or Dysfunction, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease), Cerebral Palsy, Systemic Lupus Erythematosus (SLE) or Connective Tissue Disorders (Lupus, Scleroderma), Cystic Fibrosis, Alzheimer's Disease, Schizophrenia, Dementia or Mental Retardation (including Down's Syndrome), Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Immune System Disorder? ☐Yes ☐No

a. High blood pressure, chest pain, rheumatic fever, aneurysm, heart murmur, irregular heart rhythm, heart attack, thrombosis, circulatory disorder or any other disease or disorder of the heart or blood vessels? ☐Yes ☐No
b. Diabetes, a thyroid disorder (Hyperthyroid), or other disorder of the glands? ☐Yes ☐No
c. Cancer, tumor, lymph gland disorder, cyst, anemia or any disorder of the blood or platelets? ☐Yes ☐No
d. Albumin, blood or sugar in the urine, kidney trouble, or any other disorder of the urinary or genital tract (including prostate)? ☐Yes ☐No
e. Epilepsy, convulsion, fainting spell, transient ischemic attack (TIA) or any other disorder of the brain or nervous system? ☐Yes ☐No
f. Learning disorder, depression/anxiety, eating disorder, or other psychological (emotional), mental or nervous disorder? ☐Yes ☐No
g. Arthritis, muscular atrophy, muscular system disorder, myasthenia gravis or paralysis? ☐Yes ☐No
h. Asthma, chronic bronchitis, emphysema, pneumonia, sarcoidosis, tuberculosis, shortness of breath, chronic obstructive pulmonary disease (COPD), sleep apnea, or other lung or respiratory system disorder? ☐Yes ☐No
i. Ulcer, colitis, hepatitis, pancreatitis, Crohn's disease or other disorder of the esophagus, stomach, intestines, liver, gallbladder or pancreas? ☐Yes ☐No
j. Severe injuries or any disorder or deformity of the muscles, connective tissue, bones, joints or skin? ☐Yes ☐No
k. Any impairment of sight or hearing of the eyes, ears, nose or throat? ☐Yes ☐No

3. Family Record: *(Use #7 for additional brothers or sisters.)*

Sex	Age	-Living- State of Health	Age	-Deceased- Cause of Death
Father				
Mother				
Siblings (list individually) ☐M ☐F				
☐M ☐F				
☐M ☐F				

4. Has any family member listed in #3 had cancer, diabetes, high blood pressure, heart disease, cardiovascular disease, or kidney disease? (**If Yes,** *name family member, disorder(s) and age of onset of each.)* ☐Yes ☐No

5. Have you ever used any form of tobacco? (**If Yes,** complete below.)
Type:_____ Quantity:_____ Last Used:_____ Number of years used:_____ ☐Yes ☐No

Medical Questionnaire *(Continued)* Name of Insured _____

Questions apply to Proposed Insured named above. Use the Details Section below as needed to explain "Yes" answers.

6. **Have you ever:**
   a. Used cocaine or any other illegal drugs? ☐Yes ☐No
   b. Sought treatment or counseling, or been advised to quit, reduce, seek treatment or counseling for the use of alcohol or drugs? ☐Yes ☐No
   c. Attended or been advised to attend a drug or alcohol self-help group? ☐Yes ☐No
   d. Been convicted of drug possession or distribution? ☐Yes ☐No
   e. Attempted suicide? ☐Yes ☐No

7. Details. *Give complete details of all Yes answers.*

Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practitioners, hospitals, and medical facilities consulted

8. a. What is your height? _____ weight?_____
   b. Have you lost any weight in the past year? **If yes,** *How much?* _____ *Reason?* _____ ☐Yes ☐No

9. **In the past five years, have you: (If Yes** *to a or b; give complete details of each occurrence.)*
   a. Consulted a doctor, medical or mental health professional? ☐Yes ☐No
   b. Had or been advised to have any blood tests, electrocardiograms, or other tests or studies other than a Human Immunodeficiency Virus (HIV) test or an Acquired Immune Deficiency Syndrome (AIDS) test? ☐Yes ☐No

10. Have you ever tested positive for the HIV antibody? ☐Yes ☐No

11. In the past two years, have you been advised to have any surgery or hospitalization which has not been completed? ☐Yes ☐No

12. In the past ten years, have you been under observation or received treatment in any hospital or other institution or medical facility? ☐Yes ☐No

13. Are you currently:
   a. Receiving any illness or disability pension benefits or compensation? ☐Yes ☐No
   b. Taking, or have been prescribed any medication: (**If Yes,** *provide reason and name the medication and prescribing physician.)* ☐Yes ☐No

14. Do you have any mental or physical disease or disorder, or are you under medical or psychiatric observation or treatment not already stated above? ☐Yes ☐No

15. Who is your personal physician? (**If none,** *state none.)*
   Name _____ Phone_____
   Address _____ City _____State____ Zip_____
   Date Last Seen _____ Why? _____
   What tests were made? _____
   Were the results normal? (**If no,** *give details in #16)* ☐Yes ☐No

16. Details. *Give complete details of all Yes answers.*

Question Number	Date of Occurrence	Details, diagnosis, treatment, medication, results	Duration	Name and address of medical practioners, hospitals, and medical facilities consulted

All statements and answers to the questions listed above are true, complete, and correctly recorded, to the best of my knowledge and belief. I agree: that they shall form a part of the application to the Company dated _____with policy number _____; that they shall be subject to the terms of the agreement found in same; and that they shall become a part of any policy based on this application. I will write to the Company if I chose to be interviewed if any investigative report is prepared.

I (we) hereby authorize upon request: any physician or medical practitioner; any hospital, clinic or other medically related facility; any insurance company; the Medical information Bureau; and any other organization, institution or person, that has any records or knowledge relating to the Proposed Insured's health, habits, employment, income and finances should the Company make a request, to give any such records or knowledge to: the Company; its reinsurers, affiliates and producers; the Medical Information Bureau; and third parties who perform services for the Company in order to underwrite and administer any policy issued and offer financial products and services. This authorization is valid 24 months from the date this form is signed. An exact copy of this authorization is valid as the original. A copy of this authorization will be given to me (us) or my (our) authorized representative on request.

Signed at (city and state) _____ Signature of Proposed Insured _____

On (month/day/year) _____ Signature of Witness _____

☐Agent ☐Examiner ☐Other

Fidelity Life Association, A Legal Reserve Life Insurance Company
P.O. Box 5030
Des Plaines, IL 60017
(866) 947-8739

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File Number: _____

Medical Examiner's Confidential Report

INSTRUCTIONS TO EXAMINER - This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to Proposed Insured. It should be sent to the administrative office upon completion.
Examination must be made in private. Proposed Insured must be properly prepared for careful physical examination. Please weigh and measure the Proposed Insured. Explain all positive findings under "Remarks." If for any reason you don't care to give certain special confidential information on this form, please enter such information on a separate sheet and mail directly to the Medical Director of the Company.

1. Proposed Insured _____

2. Height _____ ft. _____ in. Did you measure? ☐ Yes ☐ No Weight _____ lbs. Did you weigh? ☐ Yes ☐ No

3. MEASUREMENTS (for males only)
Chest: Full inspiration _____ in. Forced expiration _____ in. **Abdomen:** (at umbilicus) _____ in.

4. Have you ever drawn a blood specimen and mailed it along with a urine specimen? ☐ Yes ☐ No
Lab name _____

5. BLOOD PRESSURE: Initial reading _____ Additional readings _____
Report all readings. If initial reading is 140/90 or higher, or if the Proposed Insured has had hypertension or marked obesity, provide two additional blood pressure readings taken at intervals.

6. PULSE: Pulse at rest _____ Describe any irregularities

If examination is done by a physician, answer questions 7 and 8. Otherwise, go directly to question 9.

7. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

a. Brain or nervous system? (Test reflexes and coordination.) a. ☐ Yes ☐ No
b. Eyes, ears, nose, or throat? b. ☐ Yes ☐ No
c. Thyroid or lymph glands? c. ☐ Yes ☐ No
d. Heart or blood vessels? d. ☐ Yes ☐ No

(If there is history of rheumatic fever, or if you find any abnormality of heart size, rhythm or sounds, please complete question 8)

e. Lungs? e. ☐ Yes ☐ No
f. Skin or extremities? f. ☐ Yes ☐ No
g. Genito-urinary system? g. ☐ Yes ☐ No
h. Stomach or abdominal organs? h. ☐ Yes ☐ No
i. Is the liver enlarged? i. ☐ Yes ☐ No

Remarks

Name of Proposed Insured _____

Medical Examiner's Confidential Report *(Continued)*

8. To be completed if question 7d is answered Yes, or if requested: (**Explain all Yes answers under "Remarks."**)

a. Is there a history of rheumatic fever or other infectious heart disease?	a. ☐ Yes	☐ No
b. Is there a history of congenital heart disease or other valvular abnormality?	b. ☐ Yes	☐ No
c. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	c. ☐ Yes	☐ No
d. Is the first heart sound (S-1) normal?	d. ☐ Yes	☐ No
e. Is the second heart sound (S-2) normal?	e. ☐ Yes	☐ No
f. Are there gallops (S-3 or S-4)?	f. ☐ Yes	☐ No
g. Is/are there ejection sound(s) or systolic click(s)?	g. ☐ Yes	☐ No
h. Is/are there murmur(s) present?	h. ☐ Yes	☐ No

(If Yes, please describe under "Remarks," including timing (systolic or diastolic), intensity (grades 1 through 6), location and transmission or radiation. Construct a chest diagram in "Remarks" if you wish).

9. a. Does the Proposed Insured appear in any way unhealthy, disabled, or older than the stated age? ☐ Yes ☐ No
   b. Do you know of any facts bearing upon the risk by which are not brought out by the foregoing questions? ☐ Yes ☐ No
   c. Was anyone else besides the Proposed Insured present at time of exam? (**If Yes,** who? _____) ☐ Yes ☐ No

10. a. Are you acquainted with the Proposed Insured? ☐ Yes ☐ No
    If Yes, how well do you know the Proposed Insured?
    ☐ Known well ☐ Not known well
    ☐ Relative (state relationship) _____ How long known? _____
    b. Are you the Proposed Insured's personal physician? ☐ Yes ☐ No

11. Exam was done at:
    ☐ Proposed Insured's office ☐ Examiner's office ☐ Proposed Insured's home ☐ Other _____

12. How did you identify the Proposed Insured? ☐ Driver's license number: _____
    ☐ Federal or state issued photo i.d. number: _____ ☐ Other: type _____ Number _____

Remarks

I hereby certify that I have personally examined _____ in private and have correctly and fully reported my findings.

Examined at _____, dated _____, at _____ ☐ AM ☐ PM

Signature of Examiner _____ ☐ Paramed ☐ MD

Examiner

Print Examiner's name _____	Paramed company _____
Examiner's phone number _____	Address _____
Address _____	City, State, Zip _____
City, State, Zip _____	