GERMANIA LIFE INSURANCE COMPANY

Part Two of Application

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 of Proposed Insured | 2. a. Birthdate | b. Age

3. For how much insurance are you applying?

4. Family Record	Living: Age	Living: State of Health	Dead: Age at Death	Dead: Cause of Death
Father				
Mother				
Brothers and Sisters No. Living_____ No. Dead_____				

5. Have any of your parents, brothers, or sisters ever had heart disease, diabetes, or mental illness? Yes ☐ No ☐

	Yes	No
6. Have you used tobacco in any form in the past 24 months?	☐	☐
7. Have you ever received compensation for sickness or injury or been deferred or discharged from military service for physical reason?	☐	☐
8. In the past 5 years, have you used:		
a. alcoholic beverages to excess or intoxication?	☐	☐
b. barbiturates, sedatives, or tranquilizers habitually?	☐	☐
c. L.S.D., marijuana, cocaine, or any amphetamine?	☐	☐
d. heroin, morphine, or other narcotic drug?	☐	☐
9. In the past 10 years, have you been treated for alcoholism or any drug habit?	☐	☐

Give complete information regarding "Yes" answers to questions 5 thru 17, under "Details" below. Specify conditions, severity, date, duration, frequency of attacks, aftereffects, and name and address of each doctor and of each hospital.

	Yes	No	Details
10. In the past 5 years, have you been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?	☐	☐	
11. In the past 5 years, have you had an X-ray, electrocardiogram, blood study, or other diagnostic test?	☐	☐	
To the best of your knowledge and belief:			
12. In the past 10 years, have you had or been told you had:			
a. dizziness, fainting spells, epilepsy, nervous breakdown, severe headaches, or any disease or disorder of the brain or nervous system?	☐	☐	
b. asthma, hayfever, chronic cough, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system?	☐	☐	
c. high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or circulatory system?	☐	☐	
d. any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver, or gall bladder?	☐	☐	
e. nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy?	☐	☐	
f. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?	☐	☐	
g. anemia, goiter, or any disease or disorder of the blood or glands?	☐	☐	
h. rheumatic fever, diabetes, or sugar, albumin, or blood in the urine?	☐	☐	
i. cancer, or a tumor or ulcer of any kind, or venereal disease?	☐	☐	
j. varicose veins, phlebitis, or a hernia of any kind?	☐	☐	
k. any disease or disorder of the eyes, ears, nose, or throat?	☐	☐	
13. a. have you now any abnormality, deformity, disease, or disorder?	☐	☐	
b. are you receiving treatment or taking medication of any kind?	☐	☐	
14. In the past 10 years, have you :			
a. been told that you had Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC), or "AIDS" related condition?	☐	☐	
b. received advice or treatment in connection with any of these things mentioned in (a) above?	☐	☐	
c. tested postive for anti-bodies to the "AIDS" (Human T-Cell Lymphotrophic, Type III, HTLV-III) Virus, or, Lymphademopathy Associated Virus (LAV)?	☐	☐	
15. a. When did a physician or practitioner last examine, advise, or treat you? Name_____ Date_____ Address_____ b. Give reason for and results of consultation.			
16. In the past 5 years, have you consulted or been treated or examined by any physician or practitioner (a) not named above?	☐	☐	
(b) for any cause not recorded above?	☐	☐	
17. Have you lost 10 or more pounds during past 12 months? (give amount)	☐	☐	

I hereby agree that the above questions and answers shall form Part Two of my pending application for insurance, and also of any subsequent application by me for insurance in this Company, unless I then undergo another medical examination which by its terms is made a part of such application, and of subsequent applications

Dated this _____ day of _____, 20____

Witness _____ M.D.

Signature of Proposed Insured

PART THREE
To be completed in private by Examiner only.

MEDICAL EXAMINER'S REPORT

This Report is Confidential Between Company and Examiner.

Examination of heart and lungs must be with stethoscope against bared skin.

NAME

DETAILS OF "YES" ANSWERS. (Identify item.)

1. BUILD

HEIGHT (IN SHOES) FT.	HEIGHT (IN SHOES) IN.	WEIGHT (CLOTHED) LBS.	(MALES ONLY) CHEST (FULL INSPIRATION) IN.	CHEST (FORCED EXPIRATION) IN.	ABDOMEN (AT UMBILICUS RELAXED) IN.

a. Did you weigh? ☐ Yes ☐ No b. Did you measure? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

2. BLOOD PRESSURE (Record all readings)
If resting blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided:

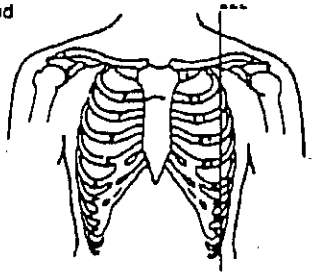
	AT REST	AFTER 50 HOPS	3 MINUTES LATER	REPEAT B. P.
SYSTOLIC				
DIASTOLIC 5TH PHASE				
3. PULSE RATE				
Irregularities Per Min.				

4. HEART a. Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No
b. Is heart enlarged? ☐ Yes ☐ No (If yes, describe)
c. Is murmur present? ☐ Yes ☐ No (If yes, complete 4d)

d. Murmur is:
☐ Constant ☐ Transmitted ☐ Systolic ☐ Apical ☐ Soft (Gr. 1-2)
☐ Inconstant ☐ Localized ☐ Presystolic ☐ Basal ☐ Mod. (Gr. 3-4)
☐ Diastolic ☐ Other ☐ Loud (Gr. 5-6)

After exercise: ☐ Unchanged ☐ Increased ☐ Decreased ☐ Absent

Show Location Of:
Apex by
Area of murmur by
Point of greatest intensity by
Transmission by
Your Impression?



5. Is there on examination any abnormality of the following: (Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Endocrine system (include thyroid and breasts)	☐	☐
c. Nervous system (include reflexes, gait, paralysis)	☐	☐
d. Respiratory system	☐	☐
e. Abdomen (including scars)	☐	☐
f. Genito-urinary system (include prostate)	☐	☐
g. Skin (incl. scars), lymph nodes, blood vessels (incl. varicose veins)	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)	☐	☐
6. Are there any hernias, hemorrhoids?	☐	☐
7. Have you any pertinent information not brought out above?	☐	☐

8. URINALYSIS:

SPECIFIC GRAVITY	ALBUMIN	SUGAR

Have specimens been sent to lab? ☐ Yes ☐ No

TO EXAMINER: Mail this completed examination directly to:
GERMANIA LIFE INSURANCE COMPANY
P. O. BOX 645
BRENHAM, TEXAS 77834-0645
800-392-2202

I certify that I, _____ made this examination at _____ ☐ A.M. _____ ☐ P.M.
Examiner's Name (Please Print)

on the _____ day of _____, 20_____.

Where was exam done? _____ Examination authorized by: _____

Examiner's social Security or Tax Identification Number must be furnished under authority of law _____

Examiner's signature _____ Examiner's address _____

GERMANIA LIFE INSURANCE COMPANY

P. O. BOX 645 • BRENHAM, TEXAS 77834-0645 • 979/836-5224 • Fax 979/277-1917

NOTICE AND CONSENT FOR HIV-RELATED BLOOD TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood 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 blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, 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 you 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 Insurer 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 and address of physician for reporting a possible positive test result:

_____

_____

_____

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 for Testing

"I have read and I understand this Notice and Consent for HIV-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, 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."

Name and address of Proposed Insured:

_____

_____

_____

_____

Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

AT 9-89