☐ Hartford Life Insurance Company
☐ Hartford Life and Annuity Insurance Company
Hartford, CT 06104-2999

THE HARTFORD

MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

PLEASE USE BLACK INK ONLY

1) Name of Proposed Insured _____ Date of Birth _____
Residence (City and State) _____

2) Primary Physician, Health Care Provider or Clinic:
Name _____ Address _____
_____ _____
Phone Number _____ _____
Date of Last Visit _____

Reason for Last Visit (Please include details of evaluation, treatment and/or referrals made.)
_____
_____
_____

	NOTE: GIVE DETAILS TO ALL "YES" ANSWERS ON NEXT PAGE	Yes	No
3.	Do you take any prescription, over the counter medication or herbal remedy? (If "Yes," please provide names and doses.)	☐	☐
4.	**Have you ever had, been treated for or had treatment recommended by a member of the medical profession for:**		
a.	High Blood Pressure; Heart Murmur or Heart Valve Abnormality; Chest Pain; Heart Surgery; Heart Attack; Abnormal Heart Rhythm; other Heart or Vascular Disease, Condition or Disorder; Stroke or Mini-Stroke (TIA)?	☐	☐
b.	Cancer, Tumor or other abnormal growth; Recurrent Infections; Lymph Gland Swelling or Enlargement; Immune System Disease, Human Immunodeficiency Virus (HIV) Infection, or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
c.	Diabetes or other Endocrine Disease; Condition or Disorder (e.g. thyroid, adrenal, pituitary, etc.)?	☐	☐
d.	Anemia; Blood Transfusion; Blood Vessel Disease; other Blood Disease, Condition or Disorder?	☐	☐
e.	Dizziness; Fainting or Loss of Consciousness; Alzheimer's Disease or Dementia; Epilepsy or Seizure Disorder; Brain or Spinal Cord Disorder; other Nervous System Disease; Depression, Anxiety, Stress or Panic Attacks; or other Psychological Disease, Condition or Disorder?	☐	☐
f.	Asthma, Chronic Bronchitis or Emphysema; other Lung Disease, Condition or Disorder; Sleep Apnea or Narcolepsy?	☐	☐
g.	Disease of the Esophagus, Pancreas or Stomach; Ulcerative Colitis or Crohn's Disease; Chronic Indigestion, Diarrhea or Vomiting; Hepatitis or other Disease of the Liver; Hernia, other Gastrointestinal Disease, Condition or Disorder?	☐	☐
h.	Bladder Disease; Kidney Disease; Prostate Disease; Sugar, Protein or Blood in the Urine; Breast Disease; other Genitourinary Disease, Condition or Disorder?	☐	☐
i.	Rheumatoid Arthritis, Lupus, other Connective Tissue Disease, Condition or Disorder; Arthritis, Rheumatism or other Joint Disease, Condition or Disorder ; Disease, Condition or Disorder of Bones, Back or Spine; Disease, Condition , or Disorder of Muscles, Ligaments or Tendons?	☐	☐
j.	Ear Disease or Eye Disease, Condition or Disorder?	☐	☐
k.	Chronic Fatigue, Fibromyalgia or Myalgia?	☐	☐
5.	Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	☐	☐
6.	Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	☐	☐
7.	Do you engage in regular exercise? (If "Yes," provide details).	☐	☐
8.	Have you lost 10 or more pounds in the last 6 months (not due to change in diet)?	☐	☐
9.	Have you, in the past 5 years, used any illicit drug or prescription drug that was not prescribed by a physician? (If "Yes," provide details to include treatment recommended or given.)	☐	☐
10.	Do you currently consume alcoholic beverages? (If "Yes," how many per day and per week?)	☐	☐
11.	Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	☐	☐
12.	Females only: Are you currently pregnant? (If "Yes," what is your due date?)	☐	☐
13.	Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	☐	☐

MEDICAL QUESTIONNAIRE APPLICATION SUPPLEMENT

14. Family History	Living or Deceased	Current Age or Age at Death	Health History (include age at onset)	Cause of Death
Father				
Mother				
Siblings				

DETAILS OF "YES" ANSWERS **(Please attach additional sheet if more space is needed.)**

Question Number	Diagnosis, reason for visit, treatment, medication, hospitalization, surgery, advice	Dates of onset and recovery	Name, address, and phone number of doctor, health care provider, clinic or hospital

I agree that, to the best of my knowledge and belief, the information herein is complete and true and shall be the basis for and a part of any insurance issued.

Dated at _____ **Date** _____

City **State** **Month** **Day** **Year**

Witness _____ _____

Signature of Examiner/Agent **Signature of Person examined**

Medical Examiner's Report

1) _____ _____
Height Weight
Did you weigh? Yes ☐ No ☐
Did you measure? Yes ☐ No ☐

2) Blood Pressure: take 3 readings

Systolic			
Diastolic			

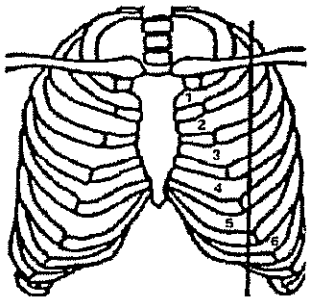
3) Pulse:

Rate	
Irregularities/mn.	

4) Please use the space provided to give details of the physical exam (→)

Cardiovascular Exam — Is there any evidence of:

a.) Peripheral Vascular Disease Yes ☐ No ☐
- ☐ Abnormal or diminished pulse
  - ☐ carotid
  - ☐ other pulse
- ☐ Other signs of PVD



b.) Enlarged heart ---------- Yes ☐ No ☐

c.) Heart murmur ---------- Yes ☐ No ☐

Murmur is

☐ Constant	☐ Transmitted	☐ Systolic	☐ Apical
☐ Inconstant	☐ Localized	☐ Presystolic	☐ Basal
☐ Trace (0-I)	☐ Mild (II)	☐ Diastolic	☐ Other
		☐ Moderate (III)	☐ Loud (IV)

ShowLocation of: --Apex by ---------- X
Area of Murmur by ---------- ◌
Point of greatest intensity by ---------- O
Transmission by ---------- →

Your impression? _____

d.) Other CV disease **(describe)**_____ Yes ☐ No ☐

Details of Questions 1 - 9
USE ONLY FOR QUESTIONS ON THIS PAGE

5) Are there any abnormalities on examination of:

a.) Eyes	Yes ☐ No ☐	f.) Nervous System	Yes ☐ No ☐
b.) Ears	Yes ☐ No ☐	g.) Lungs	Yes ☐ No ☐
c.) Mouth, Pharynx	Yes ☐ No ☐	h.) Abdomen, Liver, Spleen, Kidney	Yes ☐ No ☐
d.) Skin, Lymph Nodes	Yes ☐ No ☐		
e.) Blood Vessels	Yes ☐ No ☐	i.) Musculoskeletal System	Yes ☐ No ☐

6) Is the person's appearance unhealthy or older than stated age? Yes ☐ No ☐

7) Do you have any information or observations relating to this person's physical or mental health that are not already recorded? **(If "yes," please give details.)** Yes ☐ No ☐

8) If female, is this person menstruating today? Yes ☐ No ☐

9) Urinalysis

SPECIFIC GRAVITY	ALBUMIN	SUGAR

******SEND SPECIMEN TO LAB IN ALL CASES******

I certify that I have carefully examined_____ whose statements and signature appearing on the reverse side hereof, were made and signed in my presence and that the examination was made in private at ☐ My office, ☐ Applicant's residence, ☐ Applicant's place of business, this _____ day of _____, _____.

Examined at_____ _____ M. D. or D. O.
City State (Medical Examiner's Signature)

This examination must bear the actual date that the exam was completed and no other.

Examiner Name (Print)_____ Paramedical Co. Name _____

Address_____

Phone Number_____

Name of Agent _____Agent's Phone Number_____

HARTFORD LIFE INSURANCE COMPANIES
National Service Center
P.O. Box 59179
Minneapolis, MN 55459-0179
Telephone Number: (800) 541-6757

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the company with whom you are applying for insurance 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 counseling, at your expense, prior to being tested.

Meaning of a 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 company with whom you are applying for insurance. The test results may be disclosed as required by law or may be disclosed to employees of the company with whom you are applying for insurance who have the responsibility to make underwriting decisions on behalf of the company with whom you are applying for insurance or to outside legal counsel who needs such information to effectively represent the company with whom you are applying for insurance 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.

(over)

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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 company with whom you are applying for insurance 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 company with whom you are applying for insurance 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 company with whom you are applying for insurance 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.

_____ _____

Name of Proposed Insured (Please Print) Signature of Proposed Insured or Parent/Guardian

_____

Address

_____ _____

Date Signed

WHITE-HOME OFFICE CANARY-PROPOSED INSURED PINK-AGENT/EXAMINER