IA AMERICAN™
LIFE INSURANCE COMPANY
www.iaamerican.com

IAP/IAA Service Center
Attn: New Business
P.O. Box 19114
Greenville, SC 29602-9114

Part 2 of Application

Please print using dark ink

Section 1 – Proposed Insured

1. Name of Proposed Insured_____

Sex: ☐ Male ☐ Female Date of birth _____/_____/_____
MM DD YYYY

2. Name and address of your usual physician or medical facility _____

_____

Date and reason last consulted _____/_____/_____ _____

_____

Results, diagnosis, and/or treatment prescribed _____

_____

Section 2 – Medical Questionnaire

1. In the past 10 years, have you had, been tested for, received treatment or counseling for, or been told by a medical professional that you have: *(If "Yes," circle the appropriate item in each question and provide details.)*

	Yes	No
a. Dizziness, fainting, convulsions, epilepsy, seizures, paralysis, stroke, or severe headaches?	☐	☐
b. Depression, anxiety, stress, bipolar, mental, or nervous disorder?	☐	☐
c. Shortness of breath, bronchitis, emphysema, asthma, sleep apnea, pleurisy, or tuberculosis	☐	☐
d. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, elevated cholesterol, cardiac insufficiency, heart attack, or coronary artery disease?	☐	☐
e. Heart murmur, heart valve disorder, edema, aneurysm, or disorder of the heart or blood vessels?	☐	☐
f. Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, hepatitis, or any disorder of the intestines, spleen, pancreas, liver, or rectum?	☐	☐
g. Diabetes, high blood sugar, or sugar in your urine?	☐	☐
h. Blood or protein in your urine, or any disorder of the kidneys, bladder, prostate, or urinary system?	☐	☐
i. Any disease or disorder of the breasts or reproductive system?	☐	☐
j. Thyroid, thymus, pituitary, adrenal, or lymph gland disorder?	☐	☐
k. Cancer, sarcoidosis, tumor, polyp, or any abnormal growth?	☐	☐
l. Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?	☐	☐
m. Multiple sclerosis or any disorder of the brain or nervous system?	☐	☐
n. Anemia, bleeding or clotting disorder, or any disorder of the blood (other than HIV-related)?	☐	☐
o. Alcoholism, drug addiction, or excessive use of alcohol or drugs?	☐	☐

Details of "Yes" Answers

Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.

	Yes	No
2. In the past 10 years, have you:		
a. Been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), or AIDS-related complex (ARC)?	☐	☐
b. Used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician?	☐	☐
3. Have you used tobacco or nicotine products:		
a. In the past 36 months?	☐	☐
b. In the past 12 months?	☐	☐
4. Other than above, in the past 5 years, have you had:		
a. An examination or treatment by a doctor or medical practitioner?	☐	☐
b. Observation or treatment at a clinic, hospital, or other facility?	☐	☐
c. An EKG, stress test, x-ray, blood test or any other diagnostic test (not including HIV tests)?	☐	☐
d. A surgical operation or been advised to have a surgical operation?	☐	☐
e. A change of weight, anorexia nervosa, or bulimia?	☐	☐
5. a. If female, are you currently pregnant?	☐	☐
b. Have you ever had any complications with this or previous pregnancies?	☐	☐
6. a. Do you have a family history of diabetes, cancer, stroke, kidney disease, high blood pressure, coronary artery disease, Huntington's chorea, alcoholism, drug abuse, or mental illness?	☐	☐
b. Has any member of your immediate family (father, mother, brother, or sister) died **before age 60** from cancer (breast, colon, intestinal, or prostate) or from a cardiovascular disease (heart attack, myocardial infarct, angina, cardiac insufficiency, cerebral thrombosis, or coronary artery disease)?	☐	☐
c. Have you ever received disability benefits from any source?	☐	☐

Details of "Yes" Answers

Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.

I declare that the statements and answers contained in this Part 2 of Application are full, complete, and true to the best of my knowledge and belief and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 of Application shall be part of my application for insurance and will form part of the policy contract.

Signed at_____ this_____ day of_____ 20_____

City, State | Month | Year

_____ _____

Signature of Examiner *(Witness)* | Signature of Proposed Insured

This section is to be completed by all examiners.

All Proposed Insureds must be weighed and measured.

1. a. Height _____ft. _____in.

b. Weight _____lbs.
Weight change in past 12 months? ☐ Yes ☐ No

Lost _____ lbs. Gained _____ lbs.

Reason? _____

2. Blood Pressure:

Systolic 1) _____ 2) _____ 3) _____

Diastolic 1) _____ 2) _____ 3) _____

Take 2 readings at least 5 minutes apart.
If blood pressure is over 140/90, take a third reading.

3. Pulse _____

Rhythm _____

Irregularities?_____

If pulse is over 90, repeat in 5–10 minutes.

4. Urinalysis:
Please indicate test results in the space provided.
This section is to be completed on all examinations.

Albumin _____

Glucose _____

Blood _____

Please forward urine sample to Lab*One for urinalysis.*

5. Does the Proposed Insured appear older than the stated age? ☐ Yes ☐ No

6. Is there any evidence of alcohol, drug, or nicotine addiction? ☐ Yes ☐ No

This section is to be completed by physician only.

7. Any evidence of past or present disease of:

a. The brain or nervous system? *(Test reflexes and coordination)* ☐ Yes ☐ No

b. Head or neck? *(Include ears, eyes, and mouth)* ☐ Yes ☐ No

c. Endocrine system, breasts, or glands? ☐ Yes ☐ No

d. Chest and lungs? *(Examine on bare chest with expiratory cough)* ☐ Yes ☐ No

e. Heart and blood vessels? ☐ Yes ☐ No

f. Abdomen? *(Include liver, spleen, abnormal masses, tenderness, and surgical scars)* ☐ Yes ☐ No

g. Genitourinary system? *(Include prostate)* ☐ Yes ☐ No

h. Musculoskeletal system? *(Include spine/joint deformities)* ☐ Yes ☐ No

i. Skin *(Include xanthomas, nevi, etc.)* or lymph nodes? ☐ Yes ☐ No

8. Is there:

a. Evident arteriosclerosis? ☐ Yes ☐ No

b. Cardiac hypertrophy? ☐ Yes ☐ No

c. Cyanosis, dyspnea, or edema? ☐ Yes ☐ No

d. Cardiovascular impairment? ☐ Yes ☐ No

e. Any hernias or varicosities? ☐ Yes ☐ No

f. A heart murmur? *(Complete heart chart)* ☐ Yes ☐ No

9. Heart Chart

Murmur

Location: ☐ Apical ☐ Aortic ☐ Mitral ☐ Pulmonic

Timing: ☐ Systolic ☐ Diastolic ☐ Pre-systolic

Intensity: ☐ Soft ☐ Moderate ☐ Loud

Grade: I II III IV V VI

Is murmur constant? ☐ Yes ☐ No

Transmitted? ☐ Yes ☐ No

If transmitted, indicate to where _____

_____

Effect of exercise: ☐ Unchanged ☐ Decreased ☐ Increased ☐ Disappears

Your impression of murmur _____

_____

_____

This section is to be completed by all examiners.

10. Did you require an interpreter to question the Proposed Insured? ☐ Yes ☐ No

(*If "Yes," indicate the interpreter's name and the relationship to Proposed Insured)*

_____

11. How was the client identified? *(Please include ID type and identification number. Examples: driver's license, military ID, state ID, passport)*

_____

Remarks (Please comment fully on any abnormal findings and details of "Yes" answers)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that I made this examination at: ☐ Proposed Insured's home

☐ Proposed Insured's office

☐ Other _____

Signed at _____ this _____ day of _____ 20 _____

City, State Month Year

_____ _____

Time Signature of Examiner

_____

Examiner's Company Name