ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

MEDICAL EXAMINATION FORM

INSTRUCTIONS

- All questions must be read carefully to the proposed Insured and full answers recorded in ink.
- The medical examiner will complete Part 2 and the reverse side Part 3 of this form when medical examination is made. All medical examinations, even those partially completed, must be forwarded by the agent to the Home Office.
- If application is submitted non-medically, the agent will complete Part 2.
- Fees for examinations will be paid from the Home Office only.

Application Part 2 -

1. (Print) First Name Middle Initial Last Name

2. Birth date: Month Day Year

3. Have you ever:	Yes	No
(a) Been discharged or deferred from armed services for a physical, mental or other reason?	☐	☐
(b) Had life, health or accident insurance declined, postponed or offered differently than applied for? If yes, give date, company and reason.	☐	☐
(c) Claimed benefits for sickness or injury?	☐	☐
(d) Been treated, counseled or joined a group due to drug or alcohol use or abuse or been advised by a medical practitioner to do so?	☐	☐
(e) Used heroin, cocaine, barbiturates or other controlled substances?	☐	☐

4. Have you ever had or been told that you had or been treated for:		
(a) Disorder of the back, muscles, knees, bones or joints; gout or arthritis; deformity or amputation?	☐	☐
(b) High blood pressure, heart murmur, chest pain, heart attack, angina, stroke, rheumatic fever, varicose veins, phlebitis, coronary artery disease or any other disorder of the heart or blood vessels?	☐	☐
(c) Cancer, cyst or tumor?	☐	☐
(d) Brain or nerve disease, dizziness, fainting, convulsions, headaches, unconsciousness, paralysis, mental disease or nervous disorder including emotional problems, anxiety, depression or psychiatric treatment or counseling?	☐	☐
(e) Shortness of breath, persistent or chronic cough, asthma, chronic bronchitis, emphysema or any other lung or respiratory disorder?	☐	☐
(f) Hepatitis, jaundice, ulcer, hernia, colitis, recurrent diarrhea, rectal disease or disorder of the stomach, intestines, liver, gall bladder, pancreas or spleen?	☐	☐
(g) Sugar, blood or albumin in urine; sexually transmitted or venereal disease, kidney stone; disorder of bladder, prostate, kidney, reproductive organs; or any other disorder of the generative or urinary system?	☐	☐
(h) Diabetes, thyroid or other glandular disorders?	☐	☐
(i) Disorder of eyes, ears, nose or throat?	☐	☐
(j) Disorder of the skin or lymph glands; allergy?	☐	☐
(k) Are you pregnant? If yes, expected date of delivery: _____ 20_____.	☐	☐
(l) Have you ever had a Cesarean section or other complications of pregnancy?	☐	☐

5. Have you during the past 5 years, other than as stated above:	Yes	No
(a) Seen a physician, surgeon, chiropractor or other practitioner for a check-up, consultation, illness, injury or surgery?	☐	☐
(b) Been a patient or confined in any hospital, clinic, sanitarium or any other medical facility?	☐	☐
(c) Had an electrocardiogram, stress test, echocardiogram, angiography, x-ray, blood studies or other diagnostic test?	☐	☐
(d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐

6. Have you ever:		
(a) Had or been told by a medical practitioner he/she had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions?	☐	☐
(b) Received treatment in connection with any of the categories mentioned in (a) above?	☐	☐
(c) Tested positive for antibodies to the AIDS virus?	☐	☐

7. Have you had any parent, brother or sister who has had cancer, heart trouble, stroke, high blood pressure, diabetes or tuberculosis?	☐	☐

8. (a) Have you smoked cigarettes during the past 12 months?	☐	☐
(b) Do you use any other tobacco products?	☐	☐

9. What is your:
(a) Height and Weight _____ ft. _____ in. _____ lbs.
(b) Amount of gain or loss in weight in past year? _____

Give full details of Questions 3-8 answered "Yes."

Specify dates, duration, severity, results, the names and addresses of any physicians, hospitals, etc. **Indicate number of question to which details apply.**

Application Part 3 - Medical Examiner's Report

10. How long have you known proposed Insured?

11. (a) Height _____ ft. _____ in.
Weight_____ lbs. Did you weigh? ☐ Yes ☐ No
(b) Chest at inspiration _____ in.
(c) Chest at expiration _____ in.
(d) Girth of abdomen _____ in.
(e) Any weight change in past year? ☐ Yes ☐ No
If Yes, state amount and cause under "Details."

12. Do you find evidence of past or present disease or abnormality of the following?

	Yes	No
(a) Eyes, Ears, Nose, Throat (Measure markedly impaired vision, corrected and uncorrected.) State if hearing aid used.	☐	☐
(b) Skin, Thyroid or other Endocrine Glands	☐	☐
(c) Lungs or Pleurae	☐	☐
(d) Abdominal Organs (including Hernia)	☐	☐
(e) Musculoskeletal System (Any deformity?)	☐	☐
(f) Vascular System (Any Varicose Veins?)	☐	☐
(g) Nervous System (Any tremor or abnormal reflexes?)	☐	☐

13. Blood Pressure: (If above 140/90, report additional readings.)

				Hour Taken
Systolic				
Diastolic 5th phase				

14. Pulse:

	Resting	Reaction to Exercise: Before	Immediately After	3 Minutes After
Rate				
No. irregularities per minute				

Type of irregularity? _____

NOTE: If resting pulse 90 or over and/or irregular and if proposed Insured is able to exercise and there is no health risk, complete Reaction to Exercise portion.

15. Heart:
(a) Is heart enlarged? ☐ Yes ☐ No
(b) Is there a murmur? ☐ Yes ☐ No
(c) The murmur is –

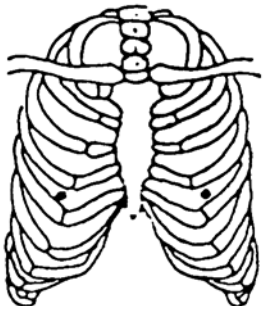
Type:	Quality:	Intensity:	Location:
☐ Systolic	☐ Soft	☐ Faint (1-2)	☐ Apex
☐ Diastolic	☐ Rough	☐ Med. (3-4)	☐ Aortic
☐ Presystolic	☐ Blowing	☐ Loud (5-6)	☐ Pulmonic

(d) Transmission –
☐ None ☐ To neck
☐ To axilla ☐ Elsewhere _____

(e) The murmur is: ☐ Constant ☐ Inconstant

(f) Murmur heard best in which position?
☐ Erect ☐ Recumbent
☐ Left lateral

(g) Indicate on diagram:
Apical impulse (x)
PMI (o)
Transmission (→) area of murmur by outline (⋰⋱)



(h) What effect does exercise have on murmur? _____

(i) Your diagnosis and/or comment: _____

16. Urinalysis: Microscopic examination is required in all cases. Please send specimen to:

Exam*One*
10101 Renner Blvd.
Lenexa, KS 66219-9752

Give full details of any "Yes" answers and add any other pertinent information or comments.

YOU MAY SEND CONFIDENTIAL INFORMATION DIRECTLY TO THE MEDICAL DIRECTOR.

I certify that I have made this examination with the results recorded on this _____ day of _____, 20_____.

in private at { My Office ☐ / Applicant's residence ☐ / Applicant's place of business ☐

X_____
Examiner's Signature

DO NOT DETACH THIS VOUCHER

MEDICAL EXAMINER'S VOUCHER

TO ASSURE PROMPT PAYMENT OF YOUR FEE THIS VOUCHER SHOULD BE FULLY COMPLETED.

Name and Address of Examiner Please Print or Rubber Stamp _____

_____

_____
Please Print

Name of Person Examined_____

Date of Exam.	Mo.	Day	Yr.	Agent

Your fee $_____

Please give Tax I.D. No.:
Individual Practitioners - SS No.
Employer I.D. No.

Form 1732

Additional Comments/Details from page 1 or 2 here:

I agree that the foregoing statements and answers are complete, true and correctly recorded and 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. I expressly waive on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder all provisions of law forbidding any physician, hospital official or employee, or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto, and I expressly authorize such persons to make such disclosures, all to the extent permitted by law.

Dated at_____ on _____, 20 _____ _____
Signature of Proposed Insured

Witness _____

This Authorization Should Be Signed In Every Case. Do Not Detach.

AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related health care facility or health care provider, insurance or reinsuring company, MIB, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of me, my spouse or my minor children, to give to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for two years from the date shown below.

_____, 20 _____ _____
Signature of Proposed Insured

Form 2946