INSTRUCTIONS

1. All questions must be read carefully to the proposed Insured and full answers recorded in ink.
2. 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.
3. If application is submitted non-medically, the agent will complete Part 2.
4. Fees for examinations will be paid from the Home Office only.

ILLINOIS MUTUAL LIFE INSURANCE COMPANY – 300 S.W. Adams Street, Peoria, Illinois 61634

Application Part 2 – Statements to Medical Examiner, or Company's Agent, if non-medical case.

1. (Print) First Name Middle Initial Last Name

2. Birth date: Month Day Year

	Yes	No
3. Have you ever:		
(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: _____, _____	☐	☐
(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:		
(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.

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 _____, _____ _____
Signature of Proposed Insured

Witness _____

Form R202-01

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, the Medical Information Bureau, 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, the Medical Information Bureau, 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.

_____, _____ _____
Signature of Proposed Insured

Form 2946

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:

		Reaction to Exercise		
	Resting	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 –

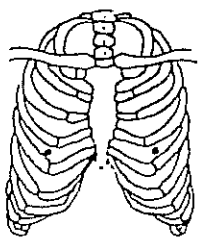
Type:	Quality:	Intensity:	Location:
☐ Systolic	☐ Soft	☐ Faint (1-2)	☐ Apex
☐ Diastolic	☐ Rough	☐ Med. (3-4)	☐ Aortic
☐ Presystolic	☐ Blowing	☐ Loud (5-6)	☐ Pulmonic

(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:

LabOne, Inc.
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 _____, _____

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

X _____
Examiner's Signature

Form R202-01

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

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 implication 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 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 of 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 responsiblity 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 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 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 physican, 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 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.

_____
Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

_____
Name of Proposed Insured

_____
Address