Medical Examination Report - Part 3

Jackson National Life Insurance Company®
Home Office: Lansing, Michigan
www.jnl.com

PLEASE PRINT. USE DARK INK.

Proposed Insured's Name (first, middle initial, last name)	SSN (include dashes)	Date of Birth (mm/dd/yyyy)

1. Have you ever been treated for, or ever had any indication of:
   a. Disorder of eyes, ears, nose, mouth or throat? ☐ Yes ☐ No
   b. Recurrent dizziness, fainting, convulsions or seizures, recurrent headaches, speech defect, paralysis or stroke, mental or nervous disorder, depression or episode of attempted suicide? ☐ Yes ☐ No
   c. Persistent shortness of breath, cough, blood spitting; bronchitis, bronchiectasis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d. Chest pain, discomfort or tightness; palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e. Jaundice, intestinal bleeding; ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, recurrent diarrhea, or other disorder of the stomach, intestines, liver, gall bladder or pancreas? ☐ Yes ☐ No
   f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? ☐ Yes ☐ No
   g. Diabetes; thyroid or other glandular or endocrine disorders? ☐ Yes ☐ No
   h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, spine, back or joints? ☐ Yes ☐ No
   i. Deformity, lameness or amputation? ☐ Yes ☐ No
   j. Disorder of skin, lymph glands, cyst, tumor, or cancer? ☐ Yes ☐ No
   k. Allergies; anemia or other disorder of the blood? ☐ Yes ☐ No
   l. Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or chronic infections? ☐ Yes ☐ No
2. Have you, in the past 10 years:
   a. Consulted with or been treated by a physician or other medical/health practitioner? ☐ Yes ☐ No
   b. Had surgery of any kind? ☐ Yes ☐ No
   c. Been a patient in a hospital, clinic, or medical facility? ☐ Yes ☐ No
   d. Had an electrocardiogram, X-ray or other diagnostic test? ☐ Yes ☐ No
   e. Been advised to have an examination, consultation, or other diagnostic test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
3. Are you presently taking any prescribed medication? ☐ Yes ☐ No
4. Have you had any medication prescribed or recommended? ☐ Yes ☐ No
5. Are you presently taking any non-prescribed medication, herbal remedies, or alternative or complimentary medicine? ☐ Yes ☐ No
6. Have you ever used tobacco in any form? If "Yes," give month and year last used: _____ ☐ Yes ☐ No
7. Have you lost or gained any weight in the past year? ☐ Yes ☐ No
   If "Yes", indicate amount of gain or loss and how long current weight has been constant _____.
8. Have you, in the past five years:
   a. Used barbiturates, heroin, cocaine, marijuana or any other controlled substance except as prescribed by a physician? ☐ Yes ☐ No
   b. Been advised by a member of the medical profession to seek treatment or counseling for alcohol or controlled substance use, or to limit alcohol use? ☐ Yes ☐ No
   c. Been counseled or treated for alcohol or controlled substance use? ☐ Yes ☐ No
   d. Attended or joined any organization for alcohol or controlled substance abuse? ☐ Yes ☐ No
9. Have you ever tested positive for the Human Immunodeficiency Virus (HIV), also known as the AIDS (Acquired Immune Deficiency Syndrome) virus? ☐ Yes ☐ No
10. Has any immediate family member died as a result of, or been diagnosed with, cancer, kidney or heart disease, diabetes or high blood pressure prior to age 70? ☐ Yes ☐ No
11. If Insured is under age 1, was the Insured's birth abnormal or premature? ☐ Yes ☐ No
    If "Yes," weight at birth: ____lbs. ___oz. Number of months premature: _____.
12. If Insured is female, have you had:
    a. Any disorder of breasts, uterus or ovaries? ☐ Yes ☐ No
    b. Any medical problems during pregnancy? ☐ Yes ☐ No
    c. Are you pregnant now? Anticipated date of delivery: _____ ☐ Yes ☐ No

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Medical Examination Report - Part 3 (Continued)

Personal Physician's Name *If none, check here:* ☐	Phone No. (include area code)
Personal Physician's Address	Date Last Seen (mm/dd/yyyy)
Reason for last visit and results	

Details of "**Yes**" answers. (If more space is needed, please attach an additional page with signature and date signed.)

No.	Dates/Duration	Diagnosis/Treatment/Result	Attending Physician's/Medical Facility's Name and Address

READ CAREFULLY BEFORE SIGNING

1) I represent to the best of my knowledge and belief that my answers and statements above are true, complete, and correctly recorded.

2) **I understand that this Medical Examination Report – Part 3 (the "Report") shall be part of the Application including but not limited to examination reports, questionnaires, supplements, and amendments, and that my statements and answers on this Report (and on the Application) must continue to be true and complete as of the date coverage becomes effective. I understand that if any of my answers and/or statements on this Report or the Application change prior to coverage becoming effective, I must inform the Company in writing; and no coverage will be in effect until the Company determines whether to provide coverage, and on what terms.**

Signature of Proposed Insured (or informant)	Date Signed (mm/dd/yyyy)

Measured Height (without shoes)	**Measured Weight** (clothed)	**Pulse** (at rest)	**Blood Pressure** At Rest	After 10 min.	Repeat if >138/85
in.	lbs.		____/____	____/____	____/____

I performed this examination at the above time and date and witnessed the proposed insured's signature. I ☐ **am** ☐ **am not** related to the applicant or producer/representative (agent).

Medical Examiner's Name	Signature
Address	

APPS PARAMEDICAL
2004 BLAKE RD
SUGAR LAND, TX 77478
(281) 242-8203

Notice and Consent for HIV-Related Blood Testing

Jackson National Life Insurance Company®
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P.O. Box 24068
Lansing, Michigan 48909-4068
www.jnl.com

USE DARK INK ONLY. PRINT OR TYPE.

Applicant's Name	Date of Birth (mm/dd/yyyy)

SSN (include dashes)	Check One	Policy/Reference No.
	☐ New Application ☐ Existing Policy	

To evaluate your insurability, the Insurer named above (the Insurer) 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.

Pretesting 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

This 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 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 of Physician for Reporting a Positive Test Result

Street

City, State, ZIP

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

I have read and I understand this Notice and Consent for HIV-Related Blood Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from the 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 explaining 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 (mm/dd/yyyy)

X

Address of Proposed Insured (number and street, city, state, ZIP)

1ST COPY- Return to Service Center 2ND COPY - Leave with Proposed Insured 3RD COPY - Producer/Representative Copy