PART II **Application for Life Insurance to The Lafayette Life Insurance Company** **Use BLACK Ink**

MEDICAL HISTORY QUESTIONNAIRE

1. Print full name of Person being examined | Age

Amount of Insurance applied for: _____

2. When were you last examined for insurance and for what company?

3. a. Name and address of your personal physician? If none, give location of Medical Records.

b. Date and reason last consulted?

c. What treatment was given or medication prescribed?

d. How much time have you lost from work during the last two years because of illness or injuries? ☐ none _____ weeks

4. a. FAMILY HISTORY

	LIVING		DEAD	
	Age	State of Health	Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				

b. Did either parent, brother or sister ever have heart disease, diabetes, stroke or high blood pressure? ☐ Yes ☐ No If "Yes," give details.

ANSWER ALL QUESTIONS IN THIS COLUMN	Yes	No
5. HAVE YOU EVER:		
a. received disability benefits?	☐	☐
b. had high blood pressure or treatment thereof	☐	☐
c. had pain or other discomfort in the chest?	☐	☐
d. had kidney stones, sugar, albumin or blood in the urine?	☐	☐
e. used barbiturates, narcotics, or other drugs, excitants or hallucinogens except as medication prescribed by a physician?	☐	☐
f. been treated for drug habit or alcoholism?	☐	☐
g. smoked cigarettes within the last 12 months?	☐	☐
6. HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS:		
a. heart murmur, palpitation, abnormal pulse or any other heart or circulatory trouble including varicose veins?	☐	☐
b. nervous or mental trouble, convulsions, epilepsy, paralysis, dizzy or fainting spells, or severe headaches?	☐	☐
c. asthma, bronchitis, emphysema, shortness of breath, pleurisy, tuberculosis or any other disorder of lungs?	☐	☐
d. ulcers or any disorder of stomach, liver, gallbladder, pancreas, intestines, appendix, or rectum including hemorrhoids and hernia?	☐	☐
e. disorder of the kidneys, bladder, prostate or genitourinary organs?	☐	☐
f. cancer, tumor, cyst, syphilis, goiter or diabetes?	☐	☐
g. gout, disorder of bone, joint, back, spine, arthritis, rheumatism or any deformity?	☐	☐
h. allergy or any disorder of the spleen or lymph glands?	☐	☐
i. disorder of the skin, eyes, ears, nose, sinuses, throat or larynx?	☐	☐
j. disorder of breasts or pelvic organs?	☐	☐
k. disorder of the immune system?	☐	☐
7. HAVE YOU WITHIN THE PAST 5 YEARS, OTHER THAN AS NOTED ABOVE:		
a. had a checkup, consultation, illness, injury, surgery?	☐	☐
b. been a patient in a hospital, clinic or other medical facility?	☐	☐
c. had an electrocardiogram, x-ray, blood study, or other diagnostic tests?	☐	☐
d. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
8. HAVE YOU RECEIVED TREATMENT BY A HEALTH CARE PROVIDER OR TAKEN MEDICATION IN THE PAST 2 YEARS?	☐	☐

	Yes	No
9. DO YOU PARTICIPATE IN REGULAR PHYSICAL EXERCISE? *If "Yes," describe type and frequency.*	☐	☐
10. HAS YOUR WEIGHT CHANGED MORE THAN 10 POUNDS IN THE PAST YEAR? *If "Yes," indicate the gain or loss & why.*	☐	☐
11. In the past ten years have you:		
(1) had or been told you had Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC"), or AIDS related conditions?	☐	☐
(2) received advice or treatment in connection with any of the categories mentioned in (1) above?	☐	☐
(3) tested positive for antibodies to the AIDS (Human T-cell Lymphotropic, Type III; HTLV-III) virus or had abnormal T-cell ratio count?	☐	☐

DETAILS OF "Yes" answers. IDENTIFY QUESTION NUMBER (Include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.)

I agree that the above questions and answers in this Medical History Questionnaire shall be considered as Part II of the application for life insurance on my life.

I have carefully read all the above questions, statements and answers and all such statements and answers are correctly recorded and are true as set down above to the best of my knowledge and may be relied upon by The Lafayette Life Insurance Company.

Dated at _____ (city) _____ (state) this _____ day of _____ yr _____

WITNESS: _____ Signature of Medical Examiner & Degree

_____ Signature of Person Being Examined

Form 1461 10/11

Part III – MEDICAL FINDINGS TO BE FILLED OUT IN PRIVATE

Make a very careful examination of heart and lungs against bare skin.

1 a. MALES ONLY:

Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus Relaxed
ft. in.	lbs.	in.	in.	in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Weight change in past year? _____ lbs. ☐ Gain ☐ Loss - Cause?

2. Blood Pressure: (Repeat if over 142/90)

(Record all readings)	1st Reading	2nd	3rd
Systolic			
Diastolic (Phase 5)			

3. Pulse:

	At Rest	exercise test (25 hops)	3 Minutes Later
Rate			
Irregularities Per Min.			

4. Heart: Is there any:

(a) Enlargement ☐ Yes ☐ No Mitral? _____

(b) Murmur(s) ☐ Yes ☐ No Aortic? _____

(c) Dyspnea ☐ Yes ☐ No Pulmonic? _____

(d) Edema ☐ Yes ☐ No Septal? _____

(describe below – if more than one, describe separately)

Constant ☐ Indicate:

Inconstant ☐ Apex by

Transmitted ☐ Murmur area by

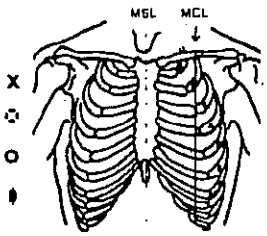
Localized ☐

Point of greatest

Systolic ☐

Presystolic ☐ Intensity by

Diastolic ☐ Transmission by



Soft (Gr. 1-2) ☐

Mod. (Gr. 3-4) ☐

Loud (Gr. 5-6) ☐

For comments and your impression? ⟶

After exercise:

Absent ☐ Decreased ☐

Increased ☐ Unchanged ☐

What is your interpretation? _____

5. Is there on examination any abnormality of the following:

(Check applicable items and give details.)

		Yes	No
(a)	eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b)	skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c)	nervous system (include reflexes, gait, paralysis)?	☐	☐
(d)	respiratory system?	☐	☐
(e)	abdomen (included scars)?	☐	☐
(f)	genitourinary system (include prostate)?	☐	☐
(g)	endocrine system (include thyroid and breasts)?	☐	☐
(h)	musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6.	Are there any hernias or any hemorrhoids?	☐	☐
7.	Are you aware of additional medical history?	☐	☐
8.	Is appearance unhealthy or older than started age?	☐	☐

9. Urinalysis:

SPECIFIC GRAVITY	ALBUMIN	SUGAR

Is specimen being sent to the Lab? ☐ Yes ☐ No

Is blood being sent to the Lab? ☐ Yes ☐ No

Lab One
P.O. BOX 2035
SHAWNEE MISSION, KS 66201

Details of "Yes" answer. (Identify them.)

I certify I have carefully examined _____ and that

the examination was made in private at
- ☐ my office
- ☐ residence of person being examined
- ☐ place of business of person being examined

Are you acquainted with person being examined? Yes ☐ No ☐

Date _____

Authorized by (AGENT) _____

_____
(Medical Examiner & Degree) (Please Print)

_____
Street Address

_____
City State

Paramedical Affiliation

This Examination Report must be mailed directly to: The Lafayette Life Ins. Co., 400 Broadway, Cincinnati, Ohio 45202-3341

FOR H. O. ONLY
☐ Approved ____
☐ Unapproved

REV. 11/99

10/11

MEDICAL HISTORY CONTINUATION SHEET

Insurance Company Name _____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Applicant's Name _____

Applicant's Signature _____

Social Security # _____

Examiner's Signature _____

Date _____

Lafayette Life Insurance Company

NOTICE AND CONSENT FOR HIV-RELATED TESTING

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.

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 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 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 possible positive test result: _____

Address: _____

_____

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
Individual Product Operations: 1-800-243-6631 ext 3751 • Fax: 1-765-477-3298

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 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

Signature of Proposed Insured
or Parent/Guardian

_____

Address

Date Signed: _____