Liberty Life Assurance Company of Boston
Service Center, 100 Liberty Way, Dover, NH 03820

Medical Evaluation Report
Supplemental Application for Individual Life Insurance

If additional space is needed for details, complete a supplemental application.

1. Proposed Insured Information

Name (First, Middle, Last) _____

Residence address (Street, City, State, ZIP) _____

Birth date_____ ☐ Male ☐ Female Policy/application number _____

2. Physician Information

Primary Care Physician name _____

Facility name _____ Telephone number _____

Mailing address (Street, City, State, ZIP) _____

Date and reason last consulted (if within the last five years) _____

What treatment was given and/or medication prescribed? _____

3. Qualifying Information

Has the proposed insured ever been diagnosed with or treated by a licensed member of the medical profession for any of the following diseases or illnesses:	**Yes**	**No**
a) Chest pain, palpitation, high blood pressure, abnormal electrocardiogram (EKG), elevated cholesterol, rheumatic fever, heart murmur, coronary artery disease, heart attack or other disorder of the heart or blood vessels?	☐	☐
b) Shortness of breath, persistent hoarseness or cough, blood spitting; chronic bronchitis, pleurisy with effusion, asthma, emphysema, tuberculosis or other chronic respiratory disorder?	☐	☐
c) Dizziness, fainting, seizures, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
d) Jaundice, intestinal bleeding; ulcer, colitis, diverticulitis, hepatitis, cirrhosis or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
e) Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, breast or reproductive organs?	☐	☐
f) Diabetes, gestational diabetes, weight loss or weight gain of more than 10 pounds in one year; thyroid or other endocrine disorders?	☐	☐
g) Neuritis, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	☐	☐
h) Deformity, lameness or amputation?	☐	☐
i) Cancer, tumor, cysts or any skin disorders?	☐	☐
j) Anemia, leukemia, or any other disease or disorder of the blood or lymph glands?	☐	☐
k) Disorder of eyes, ears, nose, or throat?	☐	☐
Has the proposed insured within the last five years:	**Yes**	**No**
l) Had any x-rays, electrocardiograms, blood tests, or diagnostic tests, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐
m) Consulted or been seen or examined by a licensed member of the medical profession or been a patient in any hospital, clinic or similar institution?	☐	☐
n) Been advised to be seen by a licensed member of the medical profession, been advised to have any diagnostic test, hospitalization or surgery which was not completed, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐
o) Been placed on a diet prescribed by a licensed member of the medical profession?	☐	☐

Details of "Yes" answers.
Provide question number, diagnosis, treatment, duration, physician name, address and telephone number.

3. QUALIFYING INFORMATION CONTINUED

Has the proposed insured:	Yes	No
p) ever used narcotics, barbiturates, marijuana or hallucinogenic drugs, except as prescribed by a licensed physician?	☐	☐
q) ever received treatment or joined an organization for alcoholism or drug addiction?	☐	☐
r) used nicotine within the past 12 months? If "Yes," provide frequency in the details section below.	☐	☐

Details of "Yes" answers. Provide question number and additional details as applicable.

	Yes	No
s) Does the proposed insured exercise? If "Yes," provide what type and frequency in the details section below.	☐	☐
t) Is the proposed insured now pregnant? If "Yes," provide the estimated delivery date in the details section below.	☐	☐
u) Does the proposed insured currently use any assisted living devices such as, oxygen, walker, crutches, cane, or wheelchair?	☐	☐
v) Does the proposed insured need supervision or assistance with any of the following activities: eating, walking, dressing, moving in and out of a bed or chair, bathing, toileting or continence?	☐	☐
w) Does the proposed insured have a family history (e.g., parent or sibling), that was diagnosed by a licensed member of the medical profession, of diabetes, high blood pressure, kidney disease, Huntington disease, cancer, mental illness, or suicide? If "Yes," please provide condition, relationship, age of onset and history in details section below.	☐	☐
x) Has the proposed insured been disabled or unable to work or perform regular activities for more than 7 consecutive calendar days in the past 12 months?	☐	☐

Details of "Yes" answers. Provide question number and additional details as applicable.

4. MEASUREMENTS

Height (ft,in) _____ Did you measure? ☐ Yes ☐ No Weight (lbs) _____ Did you weigh? ☐ Yes ☐ No

Men only Chest full inspiration _____ Chest full expiration _____ Abdomen at umbilicus _____

Pulse at rest Rate _____ Irregularities per minute _____

5. BLOOD PRESSURE

Systolic _____ Diastolic 5th phase _____ What size cuff was used? ☐ Regular ☐ Adult ☐ Large

_____ mm Hg _____ mm Hg _____ mm Hg

6. URINALYSIS

Specific gravity _____ Albumin _____ Sugar _____

Was a urine specimen collected and sent to the laboratory? ☐ Yes ☐ No

7. ASSESSMENT

	Yes	No
a) Have you previously met or consulted with this proposed insured, other than for the purpose of this insurance examination?	☐	☐
b) Did the proposed insured communicate in English?	☐	☐

c) Where was the exam completed?
☐ Examiner's office ☐ Proposed insured's residence ☐ Other _____

Details of "Yes" answers.

8. PHYSICIAN EXAM

This section to be completed by physician only.

Heart, is there any:	Yes	No
a) Enlargement, Dyspnea, Edema?	☐	☐
b) Murmur(s)? If "Yes," please complete timing, location, intensity, transmission and after exercise below.	☐	☐

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic

Location: ☐ Apex ☐ Aortic ☐ Pulmonic ☐ Other _____

Intensity: ☐ Soft (Gr 1-2) ☐ Moderate (Gr 3-4) ☐ Loud (Gr 5-6)

Transmission: ☐ Axilla ☐ Neck ☐ Precordium ☐ None ☐ Other _____

After exercise: ☐ Increased ☐ Decreased ☐ Absent ☐ Unchanged

On examination is there any abnormality of: (If "Yes," circle conditions and provide details below.)	Yes	No
c) Eyes, ears, nose, mouth, pharynx? If vision or hearing impaired, indicate degree and correction below.	☐	☐
d) Skin (including scars), lymph nodes, varicose veins, or peripheral arteries?	☐	☐
e) Lungs and thoracic cage?	☐	☐
f) Abdomen (include scars)?	☐	☐
g) Endocrine system (include thyroid and breasts)?	☐	☐
h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
i) Nervous system (include reflexes, gait, paralysis)?	☐	☐

Details of "Yes" answers. Provide question number, diagnosis, treatment and duration.

9. SIGNATURES

I declare that all statements and answers given in this application are true and complete to the best of my knowledge and belief. I also agree that: (1) no agent/insurance producer has the authority to determine insurability, waive any rights or requirements of Liberty Life Assurance Company of Boston (the Company), or make or modify any contract of insurance; (2) no information obtained by any such person will bind the Company unless set out in writing in a part of the application; (3) all statements and answers given in this application will form the basis for, and become part of, any contract of insurance issued by the Company under this application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X _____ _____ _____

Proposed Insured/Guardian Signature | Signed in: City and State | Date

X _____ _____ _____ _____

Medical Evaluator Signature (as witness) | Print Name | Medical Credentials | Date

Liberty Life Assurance Company of Boston
Service Center, 100 Liberty Way, Dover, NH 03820

Contract number _____
(Home office use only)

Supplemental Application for Individual Life Insurance

If additional space is needed, complete an additional supplemental application.

PROPOSED INSURED INFORMATION

Proposed insured's name (First, Middle, Last) _____

Birth date _____ Policy/application number _____

DETAILS

SIGNATURES

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Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X		
Proposed Insured/Guardian Signature	Signed in: City and State	Date
X		
Witness Signature	Print Name	Date