80900101

Liberty National Life Insurance Company

Medical Questionnaire

(to be completed by the Medical Examiner in his own handwriting, signed in his presence and witnessed by him.)

Print first, middle and last names of Proposed Insured.	Sex	Birthdate Mo.	Day	Yr.

1. a. Name and address of your personal physician **(if none, so state)** _____
   b. Date and reason last consulted? _____
   c. What treatment was given or medication prescribed? _____

	Yes	No
2. Do you have or have you ever been treated or ever had any known indication of:		
a. Disorder of eyes, ears, nose or throat?	❑	❑
b. Dizziness, fainting, convulsions, headache, epilepsy, paralysis or stroke, mental or nervous disorder?	❑	❑
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	❑	❑
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	❑	❑
e. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?	❑	❑
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	❑	❑
g. Diabetes, thyroid or other endocrine disorders?	❑	❑
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including spine, back or joints?	❑	❑
i. Deformity, lameness or amputation?	❑	❑
j. Tumor, cancer or disorder of skin or lymph glands?	❑	❑
k. Allergies, anemia or other disorder of the blood?	❑	❑
l. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) or tested positively for antibodies to the HIV (AIDS) virus?	❑	❑
3. Except as prescribed by a physician:		
a. Have you within the past 5 years used barbiturates, sedatives or tranquilizers?	❑	❑
b. Have you ever used LSD, marijuana, heroin, morphine, cocaine or any other controlled substance?	❑	❑
4. In the past 5 years have you used alcoholic beverages to intoxication, or have you been treated for alcoholism or any drug habit?	❑	❑
5. a. Have you used tobacco in any form within the last twelve months?	❑	❑
b. If you have been a tobacco user and quit, when did you quit? Enter month and year on this line: _____	❑	❑
6. Are you now under observation or taking treatment?	❑	❑
7. Have you had any change in weight in the past year?	❑	❑
8. **Other than above,** have you within the past 5 years:	❑	❑
a. Had any mental or physical disorder not listed above?	❑	❑
b. Had a checkup, consultation, illness, injury, surgery?	❑	❑
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	❑	❑
d. Had electrocardiogram, X-ray, blood test or other diagnostic test?	❑	❑
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	❑	❑
9. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	❑	❑
10. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	❑	❑
11. Have you ever had any disorder of menstruation, pregnancy or of the reproductive organs or breasts?	❑	❑

12. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	Yes ❑	No ❑

	Age if Living	Cause of Death?	Age at Death
Father			
Mother			

DETAILS OF "Yes" answers. **IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS:** Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce Liberty National Life Insurance Company to issue this policy or contract applied for.

Dated at _____ Date _____
City State

Witness _____
Signature of Medical Examiner

_____
Signature of Proposed Insured

80900102

Medical Examiner's Report

This examination should be made in private. If third person present, give details.

13. a. Height (In shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

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

c. Is appearance unhealthy or older than the stated age? Yes ❑ No ❑

14. Blood Pressure (Record all readings. If first reading is borderline or elevated, take a second reading)

Systolic: _____ Systolic: _____

Diastolic: _____ Diastolic: _____

15. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

16. Heart: Is there any: Enlargement Yes ❑ No ❑ Dyspnea Yes ❑ No ❑

Murmur(s) Yes ❑ No ❑ Edema Yes ❑ No ❑

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

Location		
Constant	❑	❑
Inconstant	❑	❑
Transmitted	❑	❑
Localized	❑	❑
Systolic	❑	❑
Presystolic	❑	❑
Diastolic	❑	❑
Soft (Gr. 1-2)	❑	❑
Mod. (Gr. 3-4)	❑	❑
Loud (Gr. 5-6)	❑	❑
After Exercise:		
Increased	❑	❑
Absent	❑	❑
Unchanged	❑	❑
Decreased	❑	❑

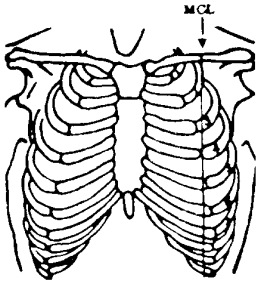
Indicate:

Apex by ✗

Murmur area by ◌

Point of greatest intensity by ○

Transmission by →



For comments and your impression:

17. Is there on examination any abnormality of the following: **(Circle 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 (include scars)?	❑	❑
(f) Genitourinary system (Include prostate)?	❑	❑
(g) Endocrine system (include thyroid and breasts)?	❑	❑
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	❑	❑
18. (a) Are there any hernias? Yes ❑ No ❑ (b) Any hemorrhoids?	❑	❑
19. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	❑	❑

20. Urinalysis by the Examiner (Required with each exam)

Specific Gravity	Albumin	Sugar

*Is specimen being sent to laboratory? Yes ❑ No ❑

Details of "Yes" answers.
(Identify item.)

REFER TO LNL MEDICAL REQUIREMENTS CHART

If a Blood Profile is required, are you sending one? **Yes** ❑ **No** ❑

FEES:

EXAM $ _____

ALSO, IF APPLICABLE:

BLOOD PROFILE $ _____

OTHER (Specify) $ _____

To facilitate payment please print name and address where check is to be mailed. (If para-Medical use Company stamp.)

***NOTICE: You are to send the urine specimen in a urine container to our laboratory if any of the following apply: (1) coverage is for over $100,000; (2) applicant is over age 60; or (3) there is any G-U history or abnormal urine findings. If a Blood Profile is being sent, use the urine container in the kit. DO NOT SEND A SECOND SPECIMEN. DO NOT MAIL SPECIMEN TO THE LIBERTY NATIONAL HOME OFFICE.**

I certify that I made this examination _____ ❑ A.M. ❑ P.M. on the _____ day of _____, 20 _____

Examination made at ❑ my office ❑ Individual's office, ❑ Individual's home, ❑ Other: _____

I have known the applicant _____ years as a _____ Requested by _____

Patient, Friend, Relative — Agent's or Manager's Name

Examiner's address: _____ Examiner's signature: _____