APPS
PARA MEDICAL SERVICES

Examined for _____
Insurance Company Policy
Name of Agent _____ No: _____
Type of Insurance: Life ☐ Health ☐ Other ☐ _____

Proposed Insured: _____ Birth Date: _____
First Name M. I. Last Name Month/Day/Year

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. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, 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, appendicitis, 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 the spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of the skin or lymph glands, unexplained fevers, AIDS or immune deficiency disease, cyst, tumor or cancer?	☐	☐
k. Allergies, anemia or other disorder of the blood?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit forming drugs?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. *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, other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐

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.)

	Age if living	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead			

9. Females only	Yes	No
a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	☐	☐
b. To the best of your knowledge and belief are you now pregnant?	☐	☐

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____, _____

Witness _____ _____
(Signature of Examiner) (Signature of Proposed Insured)

10a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	MALES ONLY: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	Details of "Yes" answers. (Identify item.)

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

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

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

12. Pulse:

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

13. 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)	☐	☐

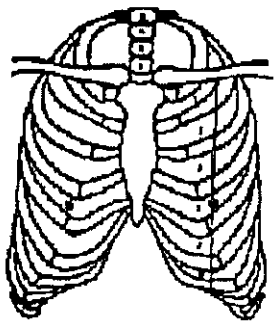
Indicate:

Apex by X

Murmur area by ◌

Point of greatest intensity by O

Transmission by →



For comments and your impression:

After Exercise:

Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

14. Is there on examination any abnormality of the following:
(*Circle applicable items and give details.*)

		Yes	No
(a)	Eyes, ears, nose, mouth, pharynx?	☐	☐
(b)	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries? (*If vision or hearing markedly impaired, indicate degree and correction.*)	☐	☐
(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)?	☐	☐
15. (a)	Are there any hernias? ☐ Yes ☐ No Any hemorrhoids?	☐	☐
16.	Does proposed insured smoke? If yes, give details	☐	☐
17.	Are you aware of additional medical history?	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar
Is specimen being sent to lab ☐ Yes ☐ No		

Are you related by blood or marriage to proposed insured?

☐ Yes ☐ No

I certify that I have carefully examined _____ of _____ (Address)

in private at ☐ my office ☐ his place of business ☐ his home this _____ day of _____, _____ at _____ A.M./P.M.

Signature of Examiner _____ Address _____

INSURER _____

ADDRESS _____

_____

"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, 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 results. 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 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 a 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 implication 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, 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 no 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 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.

_____ _____

Applicant Signature of Applicant's Parent/Guardian

_____ _____

Address Date Signed

AC 29 397

DISTRIBUTION: WHITE/HOME OFFICE - CANARY/APPLICANT - PINK/MEDICAL EXAMINER

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