1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269 Toll Free: 1-800-323-7320

PART II of application to MTL Insurance Company - Answers made to Medical Examiner

1. PRINT Full Name and Date of Birth	NT Full Name and Date of Birth Born:						
First Middle	lle Last Month/Day/Year						
2. Have you, in the past 10 years been advised of,			1	hacen or	nicotine in any form in the	Yes	No
diagnosed, tested positive for, sought consultation for, or been treated for:	Yes	No		months?			
Convulsions, seizures, paralysis, stroke, mental or nervous disorder, attempted suicide, or recurrent dizzlness, fainting or headaches?				bacco or months?	nicotine in any form in the		
Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?				an or taki	der observation by a ng any prescription		
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?			8. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease, or mental illness?				
Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or Indigestion, or other disorder of the stomach, intestines, liver or pancreas?			Father	Age if Living	Cause of Death		at ath
e. Sugar, albumin, blood or pus in urine, venereal disease, or other disorder of the kidney, bladder, prostate, breasts or reproductive organs?			Mother Brothers & Sisters				
f. Diabetes, thyroid or other endocrine disorders?	П		No. Living		.,		
g. Arthritis or disorder of the muscles or bones, spine, back or joints?			No.Dead				
h. Disorder of skin, lymph glands, cyst, tumor or cancer?			9. DETAILS	S of "Yes	" answers. (IDENTIFY QUE	STIO	N
Disorder of the eyes, anemia or other disorder of the blood?			NUMBER, CIRCLE APPLICABLE ITEMS. Include diagnoses, prescription medication(s), dates, duration				
3. Have you, within the past 10 years, been	Yes	No	and nam	es and a	ddresses of all attending ph		
medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any			and med	lical facili	nes.)		
other immunological disorder?  4. Have you in the past 10 years:	V	NI-	•				İ
a. Used barbiturates, heroin, cocaine, marijuana, or any	Yes	No					
other illegal or controlled substance, except as prescribed by a physician?							
<ul> <li>Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?</li> </ul>							
5. Other than above, have you in the past 5 years:	Yes	Nο					
<ul> <li>Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?</li> </ul>							ĺ
b. Had a checkup or other consultation?							
<ul> <li>Been a patient in a hospital, clinic, medical center or other medical facility?</li> </ul>							
d. Had an EKG, stress test or any other diagnostic test?							
<ul> <li>Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?</li> </ul>							-
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?							
6a. Have you lost or gained more than 15 lbs. in the past year? If "yes," Indicate reason and amount of gain or loss.	Yes 🗆	No		ce is nee	ded, attach on separate pag		
have read the statements and answers recorded above which have been made by me in continuation of and as part of the application for insurance. I hereby represent that such statements and answers, to the best of my knowledge and belief, are complete and true. I agree that they shall be a basis for any contract of insurance that may be issued.  Any person who knowingly presents a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.							
Dated at	-	Da	te signed			_	
Witness Medical Examiner	<u>.</u>					insu	red
Medical Examiner	THOR						
I hereby authorize any licensed physician, medical practinsurance company, the Medical Information Bureau of knowledge of me or my health, to give to the MTL Insuratine above named company, its reinsurer(s) or its reprefurnished copies, or be given details of: (a) medical adiagnosis, treatment, and prognosis of mental or physical treatment and drug or alcohol abuse treatment. A pholauthorization expires two years after the date of the policinvestigative consumer report and the Medical Informal Investigative report if deemed necessary.	litione othe ance ( esenta nd oth al con locop	r, hor org Compative, her hidition	spital, clinic panization, ir pany any su- and any co- aistory; (b) r ns. Such in this authori	nstitution ch inform onsumer nental or formation zation sh	or person, that has any rilation. This authorization shi reporting agency to view, physical conditions; (c) e shall specifically include p all be as valid as the orig	ecord all pe copy valua sychi inal.	s or ermit , be tion, atric This
Date			·	····		_ Insu	ıred

Form No. ICC09 6330-09

Mail this form to: MTL Insurance DO NOT DETACH DO NOT DETACH A MANGHER FOR WED GROUP Please Print 1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269 Toll Free; 1-800-323-7320 Name of person examined Fee \_\_\_\_\_ Name of Agent\_ Date examined . Soc. Sec. No. Name of examiner Address of examiner STREET AND NUMBER OFFICE PHONE NUMBER CITY AND STATE ΖIP MEDICAL EXAMINER'S REPORT (Both sides of this form are to be completed by the Medical Examiner) 1. a. Height Scale Weight Males Only: 9. Details of "Yes" answers, (Identify item.) Chest (full Abdomen, at Chest (forced (in shoes) (clothed) expiration) inspiration) Umbilicus ft. iπ. lbs. b. Did you weigh? 🔲 Yes ☐ No Did you measure? Yes No Is appearance unhealthy or older than stated? Yes No 2. Blood Pressure: (If systolic reading over 140 or diastolic over 90, or if Insured is markedly overweight, obtain three readings at intervals.) Initial Additional Readings Systolic Diastolic (5th Phase) 3. Pulse: At Rest After Exercise 3 Minutes Later Rate Irregularities per minute 4. Heart: Is there any: □N□ Yes Yes Enlargement Dyspnea Yes No □No Yes Murmur(s) Edema (Describe below - if more than one, describe separately.) Indicate: Location Constant Apex by X Transmitted ũ Localized Murmur area by [ Systolic П m Presystolic Diasiolic Point of greatest ā intensity by O Soft (Gr. 1-2): Transmission by -> Loud (Gr. 5-6) 🛘 For comment and your impression: After exercise: Increased Unchanged Decreased 5. Is there on examination any abnormality of the following: (Circle applicable items and give details.) <u>Yes</u> a. Eyes, ears, nose, mouth, pharynx?.... (If vision or hearing markedly impaired, indicate degree and correction.) b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?..... c. Nervous system (include reflexes, gait, paralysis, tremors)? ..... d. Respiratory system?.... e. Abdomen (include scars)? ..... Genitourinary system (include prostate)?..... g. Endocrine system (include thyroid and breasts)?....... h. Musculoskeletal system (include spine, joints, amputation, deformities)?..... Are there any hernias? Yes No Are you aware of additional medical history? No (A confidential report may be sent to the Medical Director.) Yes 8. Have you known Insured previously? Urinalysis: Specific Gravity Albumin Send urine specimen if Insured is applying for \$100,000 or more of life insurance, or is (a) hypertensive or has other cardiovascular abnormalities.

(b) markedly overweight, or (c) age 60 and over.

Date .

present, or were found in past.

Proposed Insured's Place of Business

My Office

Send 2 specimens (different days) if albumin, sugar, pus, blood or casts are

Proposed Insured's Residence

Medical Examiner

M.D.

Is specimen being sent to Company lab? Yes No

\_\_\_\_ A.M./P.M. \_\_\_

I have examined the Proposed Insured in private at:

1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269
Toll Free: 1-800-323-7320 • www.mutualtrust.com

# Texas 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 Insurers 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 State Health Services. 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.

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Name of physician for reporting a possil	ble positive test result:
Address:	
	ou are denied coverage because of that fact and you request the equire you to name a physician at that time in order to receive the
	ut you do not designate a private physician, the test results will be he Texas Department of State Health Services.
	Consent
collection of a sample of blood, oral fle	e and Consent for HIV-Related Testing. I voluntarily consent to the uid extracted from cheek and gum tissue, or urine from me, the osure of the test results as described above. I have read the est result means.
I understand that I have the right to req	quest and receive a copy of this authorization. A photocopy of this
Name of Proposed Insured (Please Prin Parent/Guardian	Signature of Proposed Insured or
Address	Date Signed
PANIA	

COMPLETE TWO FORMS: ONE MUST BE GIVEN TO THE APPLICANT and ONE MUST BE FORWARDED TO THE ADMINISTRATIVE OFFICE WITH THE APPLICATION.

Form No. 1136 TX