Medical Examination

Modern Woodmen of America
1701 1st Avenue
Rock Island, Illinois 61201
1.800.447.9811
www.modern-woodmen.org

Modern Woodmen
FRATERNAL FINANCIAL

Having made application for insurance with Modern Woodmen of America, I do hereby submit this Medical Examination and request that it be received by the Society to be made part of my underlying application.

Proposed Insured's Name _____
First Middle Last Suffix

Social Security No.:_____ Date of Birth: _____
(MM/DD/YYYY)

1. Name of primary physician, clinic or health care provider: (if none, so state) _____

Address: _____
Street City State Zip Phone

Reason last consulted (If checkup, indicate reason and outcome): _____

_____

Date last consulted: _____What treatment was given or medication prescribed: _____

_____

2a. Admitted height and weight (without shoes) Examiners: Also record measured height/ weight on Medical Examiner's Report.

Height _____ft. _____in. Weight _____pounds

b. Have you lost weight in the past year? ❑ Yes ❑ No
If YES, amount: _____ Reason for loss:_____

Explain fully all "Yes" Answers to Questions 3 – 8. (Specify question and include diagnosis, treatment, results, recovery details, dates, durations, and names, addresses and phone numbers of all doctors and hospitals)

3. In the past 7 years, have you been treated or diagnosed by a physician for:	**Yes**	**No**
a. disease or disorder of eyes, ears, nose or throat?	❑	❑
b. dizziness, fainting, convulsions, epilepsy, paralysis, stroke, sleep apnea, depression, anxiety, attempted suicide, or other mental or nervous disease or disorder?	❑	❑
c. shortness of breath, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD) or other disease of the lungs or chronic respiratory disorder?	❑	❑
d. high blood pressure, cholesterol abnormality, chest pain, heart murmur, heart attack, arrhythmia, heart valve disorder, coronary artery disease or other disease or disorder of the heart or blood vessels?	❑	❑
e. ulcer, colitis, intestinal bleeding, hepatitis, diarrhea of more than one week's duration, or other disease or disorder of the stomach, esophagus, intestines, liver or gallbladder?	❑	❑
f. sugar, protein or blood in urine or other disease or disorder of the kidney or bladder?	❑	❑
g. diabetes, leukemia, tumor, cancer, thyroid or glandular disorder, lupus, patches in mouth, skin rash or other disease or disorder of the skin?	❑	❑
h. neuritis, neuropathy, arthritis, back disorder, amputation or other disease or disorder of the muscles or bones?	❑	❑
i. allergies, anemia, fever persisting over one month, swollen glands in the neck, armpits or groin or other blood or lymph disease or disorder?	❑	❑
j. disorder of prostate, reproductive organs or breasts or a sexually transmitted disease?	❑	❑
k. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	❑	❑

Proposed Insured's Name: _____ Date of Birth:_____
(MM/DD/YYYY)

	Yes	No	Explain fully all "Yes" Answers to Questions 3 – 8. (Specify question and include diagnosis, treatment, results, recovery details, dates, durations, and names, addresses and phone numbers of all doctors and hospitals)
4. Are you presently receiving treatment or taking any medication or herbal supplements **as prescribed or directed by a physician?**	❑	❑	
5. Have you within the past 7 years: **a.** used marijuana, cocaine, methamphetamine, heroin, sedatives, stimulants, hallucinatory drugs, opiates, narcotics, or prescription medications **other than as prescribed by a physician?**	❑	❑	
b. received or been advised to seek counseling, treatment, or been arrested for the use or possession of alcohol or drugs?	❑	❑	
6. <u>Other than as stated in answers to Questions 1-5 of this examination,</u> have you within the last 7 years: **a.** consulted, been examined or treated by any physician or practitioner?	❑	❑	
b. had any illness, injury or surgery?	❑	❑	
c. been a patient in or been examined or treated at a hospital, clinic, or other medical facility?	❑	❑	
d. had an electrocardiogram (EKG), biopsy, heart study, colonoscopy, pap smear, mammogram, blood test, sleep study, x-ray or other diagnostic test?	❑	❑	
e. been advised to have any diagnostic test, hospitalization, treatment or surgery which was **<u>not</u>** completed?	❑	❑	
7. To the best of your knowledge, have any of your parents, brothers or sisters ever had cancer, diabetes, high blood pressure, stroke, Huntington's disease, polycystic kidney disease, heart disease, or other cardiovascular disorder before age 60? (If **YES**, specify person, condition, and age at death if deceased)	❑	❑	
8. Age 18 & up **a.** Have you used any nicotine or tobacco products in the past 12 months?	❑	❑	
b. Have you used any nicotine or tobacco products in the past 36 months?	❑	❑	

Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false, deceptive, incomplete, or misleading statement may be guilty of a crime.

To the best of my knowledge and belief the foregoing statements and answers are true, complete and correctly recorded. It is agreed that all such statements and answers shall become a part of my application to Modern Woodmen of America with the same force and effect as if they were included in my underlying application.

Date: _____ State signed in: _____

_____ _____
Medical Examiner Proposed Insured Signature

Medical Examination

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(Medical Examiner's Report)

Proposed Insured's Name _____
First Middle Last Suffix

Date of Birth: _____
(MM/DD/YYYY)

9. Height: _____ feet _____ inches (without shoes) Weight: _____ pounds (An accurate weight is required on one scale without shoes.)

The scale used accurately weighs to _____ pounds.

Did you weigh and measure? ❑ Yes ❑ No If no, explain: _____

10. Pulse rate at rest: _____ per minute

Was pulse regular? ❑ Yes ❑ No If no, explain: _____

11. Blood pressure: Please record 1st reading. If reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd readings at 5 minute intervals.

	First Reading	Second Reading	Third Reading
Systolic			
Diastolic			

	Yes	No
12. Is appearance unhealthy or older than stated age?	❑	❑
13. Any obvious physical or mental impairment?	❑	❑
14. Do you suspect anything unfavorable such as excessive use of alcohol or drugs?	❑	❑
15. Are you aware of additional medical history?	❑	❑
16. Did the proposed insured require any assistance from a third party to understand and answer the questions from this exam?	❑	❑
17. Does the proposed insured display any signs or symptoms of confusion, dementia or memory loss?	❑	❑
18. Did the proposed insured require any assistance, either by device (cane, walker, wheel chair, etc.) or third party, to arrive at and participate in this examination?	❑	❑
19. Are you related to the proposed insured or agent?	❑	❑

Details of "Yes" answers to Questions 12-19. (Specify question). Do not continue explanations from form 2502 on this form as this is not signed by the proposed insured.

20. What proof of the proposed insured's identity did you review? ❑ Driver's License
❑ Other picture ID(specify): _____

21. How long have you known the proposed insured?
❑ _____ ❑ Just met

I certify that the above report is a record of an examination made by me of the proposed insured on: Date _____

Examiner's Name (please print): _____

Examiner's Signature: _____

Examiner's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Company: _____ Fee: $_____ Agent's Name: _____

Return this form to Modern Woodmen of America

Instructions to the Examiner for Medical Examination and Medical Examiner's Report

Modern Woodmen of America
1701 1st Avenue
Rock Island, Illinois 61201
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1. Please consult the Underwriting Requirements Chart revised 1/2014 for a listing of the requirements to be used on all cases except foreign-born applicants in the U.S. less than 2 years. For foreign-born applicants in the U.S. less than 2 years please consult the Foreign-Born Underwriting Requirements Chart. Additional fees for tests not specifically authorized will not be honored.

2. These forms are to be used for proposed insureds ages 18 and above.

3. Examinations must be made in private. Field representatives and/or family members should not be present during the examination.

4. All examination questions on the Medical Examination must be asked by the medical examiner and answers should be printed by the examiner. Any changes should be initialed by the proposed insured.

5. If the proposed insured does not speak fluent English and an interpreter is required to complete the examination, the medical examiner should note the relationship of the interpreter to the proposed insured and the language spoken on the Medical Examiner's Report. The interpreter must be a disinterested adult (someone other than the field representative or beneficiary).

6. If explanations on the Medical Examination form do not fit on those pages, continue on a new exam or separate sheet which is signed by both the proposed insured and examiner and dated. All answers and explanations given for the questions on page 1 and 2 of the Medical Examination form must be above the proposed insured's signature and dated. A copy of this form is included with any certificate issued; the Medical Examiner's Report is not included in the certificate.

7. The proposed insured must sign the Medical Examination form in the examiner's presence. The examiner should verify the identity of the proposed insured with a valid picture ID.

8. The Medical Examination form and the Medical Examiner's Report must be completed and signed by the medical examiner. The information on the bottom of the Medical Examiner's Report constitutes your bill for service.

9. Medical Examination and Medical Examiner's Report mailing instructions:

   a. Please return Pages 1 through 3 in order and **DO NOT RETURN THE INSTRUCTIONS PAGE**.

   b. <u>If you are contracted through an approved paramed service</u>, refer to your company's order instructions on exam handling.

   c. <u>If you are the proposed insured's physician</u>, please mail to the below address.

      Modern Woodmen of America
      Underwriting Department
      1701 First Avenue
      Rock Island, IL 61201

10. Blood and urine specimens should be sent to:

      Heritage Labs, Inc.
      560 N. Rogers Rd.
      Olathe, KS 66062
      Ph. 913-764-1045