Application **Part 1**

MONUMENTAL LIFE INSURANCE COMPANY

Home Office: Baltimore, MD • Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

MEDICAL QUESTIONS

Full name of person proposed for insurance: Date of Birth (Month/Day/Year):

Name, address and telephone number of your personal physician. (If none check box) ☐ None

Date and reason last consulted?

What treatment was given or medication prescribed?

MEDICAL QUESTIONS - Each question must be individually asked and answered.

To the best of your knowledge, has any Proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

	Yes	No
1) Illness, injury or disease of the eyes, ears, nose or throat?	☐	☐
2) Epilepsy, seizures, chronic headaches, head injury, paralysis, or other disorder of the nervous system?	☐	☐
3) Anxiety, depression, affective disorder, eating disorder, psychotic disorder, or other psychiatric treatment?	☐	☐
4) Asthma, emphysema, tuberculosis, shortness of breath, persistent hoarseness or cough, or other respiratory illness or disease?	☐	☐
5) High blood pressure, heart attack, stroke, heart murmur, palpitation, arrhythmia, chest pain, rheumatic fever, or other illness or disease of the heart or circulatory system?	☐	☐
6) Ulcer, colitis, Crohn's disease, diverticulitis, hepatitis, intestinal bleeding, or illness or disease of the gallbladder, stomach, intestines, or liver?	☐	☐
7) Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system?	☐	☐
8) Diabetes, thyroid disorder, cholesterol elevation, anemia, or other illness or disease of the blood?	☐	☐
9) Arthritis, gout, lupus, illness, injury or disease of the back, spine or joints, or other illness, injury or disease of the muscles, bones or skin?	☐	☐
10) Cysts, tumor, skin cancer or any other cancer or malignancy?	☐	☐
11) Any illness or disease of the male or female reproductive organs, sexually transmitted disease, prostate problems, irregular menstruation or abnormal pap test?	☐	☐
12) An examination, treatment or consultation with a doctor or health care provider other than above?	☐	☐
13) Had or been advised to have a check-up, consultation, lab test, EKG, x-ray, or other diagnostic test?	☐	☐
14) Received or been advised to have treatment for drug usage, whether legal or illegal, alcoholism or been a member of AA?	☐	☐
15) Are you currently under the observation of a physician or taking medication?	☐	☐
16) Family History: Is there a history of cardiovascular disease or cancer in parent/siblings prior to age 60?	☐	☐
17) Do you participate in a regular, supervised exercise program or other organized sport?	☐	☐
18) Do you know of any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure, Diabetes, or committed suicide? (Please show age at onset and/or date of death).	☐	☐
19) Have you had any weight change in the past year?	☐	☐
20) Have you or any Proposed Insured EVER been diagnosed as having or been treated for AIDS, or AIDS Related Complex (ARC) or tested positive for the AIDS virus?	☐	☐

FAMILY HISTORY

	Age if Living?	Status of Health	Age of Death?	Cause of Death?
Father				
Mother				

Give details regarding "yes" answers number 1-20 (Please print)

Question No.	Disease, symptom, injury, etc.	Dates	Duration	No. of Attacks	Name and Address of Attending Physicians and Hospitals

I certify and represent that I have read and understand all the statements and answers herein and in Part 1 of my application; that they are true and correct, and are correctly recorded whether written in my own hand or not. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. I agree that this and any other application, any amendments or endorsements and any policy or policies issued based on this and any other application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgement and ratification of any corrections made in the application; except, that no change in amount of insurance, age at issue, classification, kinds of insurance or benefits will be made unless agreed in writing by the applicant and an officer of the Company.

I further acknowledge that the information contained in Parts 1 and 2 of this form is being obtained on behalf of Monumental Life Insurnace Company and that such information will be released to the Company, its agents, employees, representatives and reinsurers.

Date _____

_____
Signature of Proposed Insured

_____
Examiner

_____
Signature of Parent if insured is a minor

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Part 2 — MEDICAL EXAMINER'S REPORT

21. Your patient? ☐**Yes** ☐**No** If so, how long? _____

22. **Height** (in shoes) Ft. In. **Weight** (clothed) Lbs.

Males Only

Chest (full inspiration) In.	**Chest** (forced expiration) In.	**Abdomen** (at umbilicus) In.

Did you weigh? ☐**Yes** ☐**No** Did you measure? ☐**Yes** ☐**No**

23. Blood Pressure(Record **all** readings.) If initial blood pressure is elevated(140/90 or over), please give repeat readings.

	Initial Reading	**After Exercise**	**3 Minutes Later**
Systolic			
Diastolic 5th phase			
24. Pulse	**At Rest**	**After Exercise**	**3 Minutes Later**
Rate			
Irregularities per min.			

25. Heart

Is there any:	Yes	No
Enlargement	☐	☐
Dyspnea	☐	☐
Edema	☐	☐
Murmur(s)*	☐	☐

*Describe below. If more than one, describe separately.)

Murmur Location	**No. 1**	**No. 2**
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:

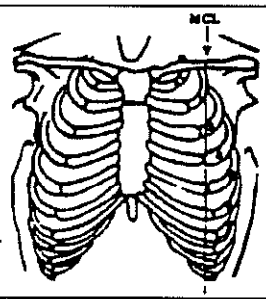
Apex by X

Murmur area by ◌

Point of greatest intensity by O

Transmission by →

For comments and your impression.



26. 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 (include scars), lymph nodes, varicose veins or pheripheral 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)?	☐	☐
27. a. Are there any hernias?	☐	☐
b. Any hemorrhoids?	☐	☐

(Your confidential report may be sent to the Medical Director)

28. Are you aware of additional medical history?

29. Specific Gravity	Albumin	Sugar

Please complete the Dipstix. Please send a portion of the specimen to Home Office Reference Laboratory, P.O. Box 2035, Shawnee Mission, Kansas 66201.

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

Examination made at the request of _____, Agent.

I certify that I have made this examination of _____

at _____ on _____ ___ at A.M./P.M.
(Place of Examination) (City) (State)

and that the foregoing questions have been asked and the answers of the Applicant recorded as stated.

Signature _____ M.D., Medical Examiner

MAIL EXAMINATION DIRECTLY TO: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

☐ **Life Investors Insurance Company of America**
☐ **Monumental Life Insurance Company**
☐ **Stonebridge Life Insurance Company**
☐ **Transamerica Life Insurance Company**
☐ **Western Reserve Life Assurance Co. of Ohio**

4333 Edgewood Road NE, Cedar Rapids, IA 52499

Notice and Consent for HIV-Related Testing TEXAS

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 results 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 Results

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 positive test result

_____
Street Address

_____
City, State, Zip Code

_____
Telephone

Notice and Consent for HIV-Related Testing TEXAS

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 not 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 Testing.* I voluntarily consent to the withdrawal 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.

Proposed Insured (*Please Print*)	Signature of Proposed Insured
Street	Date Signed
City, State, Zip Code	Date Birth