MONUMENTAL LIFE INSURANCE COMPANY
Administrative Offices:
2 E. Chase Street/Baltimore, MD 21202
300 W. Morgan Street /Durham, NC 27701

Proposed Insured: _____

Policy #: _____

MEDICAL EXAM - APPLICATION FOR INSURANCE
(TO BE COMPLETED BY MEDICAL EXAMINER)

1.a. Name, address, and phone number of your personal physician or other medical care provider. (If none, so state):

b. Date and reason last consulted: _____

c. Treatment given or medication prescribed: _____

d. List all current medications taken: _____

2. Has proposed insured ever had, been treated for, or been advised to be treated for: (SHOW DETAILS OF ALL 'YES' ANSWERS ON IN SPACE PROVIDED.)	Yes	No
a. Disorder of eyes, ears, nose, or throat?	[ ]	[ ]
b. Anxiety, depression, dizziness, fainting, convulsions, epilepsy, headache, migraine, paralysis, mental retardation, schizophrenia, seizures, speech defect, multiple sclerosis,stroke, or mental or nervous disorder?	[ ]	[ ]
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, allergies, emphysema, tuberculosis, sleep apnea, pulmonary disease, chronic respiratory disorder, pneumonia, or throat disorders?	[ ]	[ ]
d. Chest pain, palpitation, high blood pressure, rheumatic fever, irregular heart beat, high cholesterol, aneurysm, blood clot, stroke, heart murmur, heart attack or other disorder of the heart, blood vessels, or circulatory system?	[ ]	[ ]
e. Chronic diarrhea, jaundice, intestinal bleeding, ulcer, hernia, hepatitis, cirrhosis, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver, gallbladder or digestive system?	[ ]	[ ]
f. Sugar, albumin, blood, pus in urine, sexually transmitted disease, stone or other disorder of kidney or bladder?	[ ]	[ ]
g. Diabetes, thyroid, pancreas, abnormal growth or function (including dwarfism and gigantism) or other endocrine or gland disorders?	[ ]	[ ]
h. Neuritis, sciatica, rheumatism, arthritis, gout, lupus, scleroderma, or disorder of the muscles or bones, including the spine, back, neck, or joints?	[ ]	[ ]
i. Deformity, lameness, or amputation, or chronic or recurrent back pain?	[ ]	[ ]
j. Disorder of the skin, lymph glands, cyst, tumor, cancer, including leukemia, Hodgkin's Disease, myeloma, or malignancy of any organ or body part?	[ ]	[ ]
k. Allergies, anemia, or other disorder of the blood?	[ ]	[ ]
l. Any disease or abnormality of the breast?	[ ]	[ ]
m. Any disease or disorder of the immune system?	[ ]	[ ]
n. Any disease, disorder or abnormality of the prostate, uterus, or ovaries, or complications of pregnancy, or other disorder of the reproductive organs?	[ ]	[ ]
o. Any mental or physical disorder not revealed above?	[ ]	[ ]
3. Are you now under observation, taking medication, or receiving treatment not revealed above?	[ ]	[ ]
4. In the past year, have you had a gain or loss of weight of more than 10 pounds?	[ ]	[ ]
5. Other than above, within the past 5 years, have you:		
a. Had a check up, consultation, illness, injury, or surgery?	[ ]	[ ]
b. Gone to a hospital, clinic, or other medical facility?	[ ]	[ ]
c. Had an electrocardiogram, X-ray, or other diagnostic test?	[ ]	[ ]
d. Been advised to have any diagnostic test, hospitalization, or surgery that was not completed?	[ ]	[ ]
6. Have you used any tobacco or nicotine products in the last 12 months?	[ ]	[ ]
7. Have you ever used marijuana, cocaine, hallucinogens, heroin, barbiturates, amphetamines, or other habit forming drugs except as prescribed by a licensed physician?	[ ]	[ ]
8. Have you ever received treatment or joined an organization for alcoholism or drug use or been advised to discontinue the use of alcohol or drugs?	[ ]	[ ]
9. Have you ever been medically diagnosed as having, or been treated for Acquired Immune Deficiency Syndrome (AIDS)?	[ ]	[ ]
10. Have you ever tested positive for Human Immunodeficiency Virus antibodies (HIV antibodies)?	[ ]	[ ]
11. Have you ever had military service deferment, rejection, or discharge for a mental or physical condition?	[ ]	[ ]

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Medical Application (Continued)

12. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness, or disability?..... [ ] [ ]
13. Any family history of Tuberculosis, diabetes, cancer, high blood pressure, heart, or kidney disease, mental illness or suicide?..... [ ] [ ]
14. Family History:

	Age if Living	Age at Death	Cause of Death
Biological Father	_____	_____	_____
Biological Mother	_____	_____	_____
Deceased Brothers and/or Sisters	N/A	_____	_____
		_____	_____

Number Brothers/Sisters Living: _____ Number Brothers/Sisters Deceased: _____

Details of 'Yes' answers should include, but not be limited to: Diagnoses, test results and findings, frequency of occurrences, durations, hospitalizations, procedures, surgeries, medications, dates, and names and addresses of all attending physicians and medical facilities. Identify question number. Indicate applicable items. Use reverse side if necessary.

I acknowledge and agree that the answers to the above questions were given by me, that these answers will be relied upon by the Company in issuing the policy, and that these answers shall become a part of the policy. I also acknowledge and agree that these answers are true and correct to the best of my knowledge and belief, and that they shall be part of my application. I expressly waive, to the extent permitted by law, all provisions of law that forbid any physician, or other person, from disclosing any knowledge or information that he may have acquired by attending or examining me.

Signed at _____ _____
City State Signature of Proposed Insured

Date _____ _____
Examiner - Please Print

Witnessed by: _____ _____
Signature of Medical Examiner Exam Firm - Please Print

Proposed Insured: _____

Policy #: _____

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau, Inc., Consumer Reporting Agency, or employer, having information as to diagnosis, treatment, and/or prognosis with respect to any physical or mental condition (including drug and/or alcohol abuse, AIDS, and AIDS related diseases) of any proposed insured, and any other non-medical information of any proposed insured, to give to the Monumental Life Insurance Company, or its legal representative or reinsurers, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Monumental Life Insurance Company to determine eligibility for insurance and eligibility for benefits. Any information obtained will not be released by the Monumental Life Insurance Company, EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., Consumer Reporting Agency, investigative agencies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request a copy of this Authorization. This Authorization will be valid for twenty-six months from the date shown below. A photocopy or facsimile of this Authorization will be as valid as the original.

_____
Date

_____
Proposed Insured
(If proposed insured is a minor, signature of Parent, Guardian or person liable for child's support)

_____
Name of Minor Child

MEDICAL EXAM - APPLICATION FOR INSURANCE
(MEDICAL EXAMINER'S CONFIDENTIAL REPORT)

1a.	Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Expiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

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

2. Blood Pressure (Record ALL readings):

		At Rest	After Exercise	3 Minutes Later
Systolic				
Diastolic	4th phase			
	5th phase			

3. Pulse:

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

4. 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

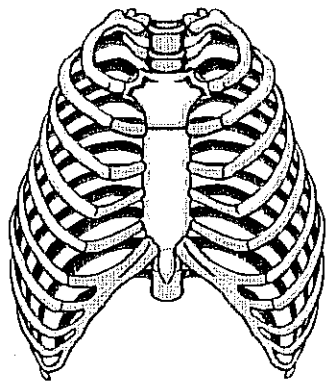
Apex by ✚

Murmur area by ◯

Point of greatest intensity by ◯

Transmission by →

For comments and your impression



Policy # _____

Proposed Insured: _____

Birthdate: ____/____/____

SS # ____-____-____

Driver's License # _____

District Name/# _____

Medical Examiner _____

Examining Firm _____

Address _____

5. 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, indicated 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, joint, amputations, deformities)?	☐	☐
6.	(a) Are there: Any hernias? ☐ Yes ☐ No (b) Any hemorrhoids?	☐	☐
7.	Are you aware of additional medical history?..... (A confidential report may be sent to the Medical Director)	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar

ALL SPECIMENS MUST BE SENT TO DESIGNATED LABORATORY. REFER TO COMPANY SPECIFICATIONS.

USE REVERSE SIDE FOR ADDITIONAL REMARKS

I certify that I have carefully examined **(print name of proposed insured)**, _____ of **(proposed insured's home)** _____ in private at **(exam location)** _____ this _____ day of _____, year of _____ at _____ o'clock A.M./P.M. for insurance of $ _____ on the proposed insured's life; that the proposed insured's answers made to the Medical Examiner on the Part 2-Medical are recorded exactly as made by the proposed insured to me.

IMPORTANT: This examination is the property of Monumental Life Insurance Company, and when completed, must be mailed immediately to Monumental Life Insurance Company, or its authorized representative, and not given to any other person.