UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY
3300 Mutual of Omaha Plaza, Omaha, NE 68175

STATEMENTS TO EXAMINER SUPPLEMENT FOR INDIVIDUAL LIFE INSURANCE APPLICATION

PROPOSED INSURED(S) INFORMATION

Name (First, Middle Initial, Last)	Date of Birth
Home Address (Street, City, State, ZIP)	Social Security Number

PHYSICIAN INFORMATION

Name, Address and Telephone Number of Personal Physician	Date Last Seen	State Reason, Findings and Treatment

FAMILY HISTORY

Do you have a deceased parent(s) and/or sibling(s)? ☐ **Yes** ☐ **No**
(If Yes, please list details below. If more space is needed, use the Comments section.)

	Age at Death	Cause of Death
Father		
Mother		
Sibling 1		
Sibling 2		
Sibling 3		

MEDICAL HISTORY

1. Have you ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ **Yes** ☐ **No**

2. Have you ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:

(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, pacemaker or defibrillator, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke? **Yes** ☐ **No** ☐

(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea, or shortness of breath? **Yes** ☐ **No** ☐

(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder? **Yes** ☐ **No** ☐

(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor or disease of the prostate, testis, breast, uterus, or ovaries? **Yes** ☐ **No** ☐

(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia? **Yes** ☐ **No** ☐

(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder? **Yes** ☐ **No** ☐

(g) any disease, or disorder of vision, or hearing? **Yes** ☐ **No** ☐

(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder? **Yes** ☐ **No** ☐

Medical History Continued

3. In the past 10 years, have you:

(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a member of the medical profession? ..... **Yes** ☐ **No** ☐

(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? ..... **Yes** ☐ **No** ☐

(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? ..... **Yes** ☐ **No** ☐

4. In the past 12 months, have you:

(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems? **Yes** ☐ **No** ☐

(b) received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?..... **Yes** ☐ **No** ☐

(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? ..... **Yes** ☐ **No** ☐

(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?..... **Yes** ☐ **No** ☐

(e) had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)?..... **Yes** ☐ **No** ☐

5. In the past two years, have you (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? ..... ☐ **Yes** ☐ **No**

(If Yes, please list details below. If more space is needed use the Comments section.)

Medication Name (copy from pharmacy label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage/ Frequency

6. In the past five years, have you consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? ..... ☐ **Yes** ☐ **No**

(If Yes, please list details below. If more space is needed use the Comments section.)

Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

Comments

List details of Yes answers. Identify question number and provide additional information necessary. If more space is needed, use an additional sheet of paper.

Agreement

I represent the information in this application is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.
Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: _____ _____ Date _____
City State Mo Day Yr

Witness _____ _____
Signature of Examiner Signature of Proposed Insured

Confidential Medical Report

Mail Direct to: Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

Applicant Name: _____
Print Name

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

7. **(b)** Did you weigh? ..... Yes ❑ No ❑
(c) Did you measure? ..... Yes ❑ No ❑
(d) Was blood drawn? ..... Yes ❑ No ❑

Blood Pressure (Record ALL readings.) Repeat readings if elevated.

8.			
Systolic			
Diastolic Fourth phase			
Fifth phase			

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

10. Is appearance unhealthy or older than stated age? ..... Yes ❑ No ❑
11. Are there any signs of frailty (weight loss, exhaustion, weakness, slow walking speed, low physical activity, difficulty standing up or impaired balance)? ..... Yes ❑ No ❑
12. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.) ..... Yes ❑ No ❑

This section is to be completed only by a medical doctor (if required).

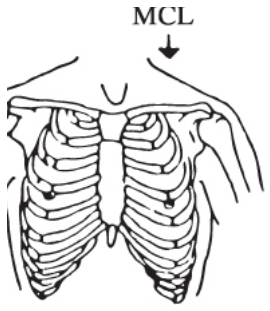
13. Heart: Is there any:

Enlargement? Yes ❑ No ❑	Dyspnea? Yes ❑ No ❑	Murmur(s)? Yes ❑ No ❑	Edema? Yes ❑ No ❑

(Describe below — if more than one, describe separately.)

Location	Murmur No. 1	Murmur 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: ..... Φ
Point of greatest
Intensity by: ..... Φ
Transmission by: ..... ➡



For comments and your impression

14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) .. Yes ❑ No ❑
(b) Skin (include scars); varicose veins, peripheral arteries, discolorations, open sores or rash? ..... Yes ❑ No ❑
(c) Lymph nodes? ..... Yes ❑ No ❑
(d) Nervous system (include reflexes, gait, paralysis)? ..... Yes ❑ No ❑
(e) Respiratory system? ..... Yes ❑ No ❑
(f) Abdomen (include scars)? ..... Yes ❑ No ❑
(g) Genitourinary system (include prostate)? ..... Yes ❑ No ❑
(h) Endocrine system (include thyroid and breasts)? ..... Yes ❑ No ❑
(i) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... Yes ❑ No ❑

15. Did your examination reveal any condition requiring further investigation or immediate treatment? ..... Yes ❑ No ❑
(If "Yes," did you advise the Proposed Insured or refer the Proposed Insured to his or her personal physician? ..... Yes ❑ No ❑

List details of "Yes" answers to questions 10 through 15. Identify question number and use additional sheet if necessary.

Time of examination _____a.m. _____p.m. Place: ❑ Your Office ❑ Other (Explain) _____
Amount of Insurance $ _____ Name of Agent _____ Agency Name _____

EXAMINER _____ SIGNATURE _____
Please Print Name Title Title

ADDRESS _____ _____
Street City State ZIP Code Mo Day Year