Part II of my application for Insurance to:

Mutual Savings Life
Insurance Company • A UNITRIN Company
HOME OFFICE: Decatur, Alabama 35601

The Original Application will be Part I.

Name of Proposed Insured	Birth Date	Sex	Source of Identification (picture I.D. only) ☐ Driver's License ☐ State I.D. Card ☐ Other:

Social Security Number:	Driver's License Number:	State of Issue	Amount Applied for:	Name, Address and Phone Number of Personal Physician (If none, so state):

MEDICAL HISTORY (to be recorded by medical examiner):	Yes	No
So far as you know and believe ---		
1. Have you ever had any physical disability or impairment?		
2. Is your health impaired at present?		
3. Have you had a weight gain ☐ or loss ☐ in past year? (If "Yes," how much?)		
4. Is any medication being taken? (If "Yes," what?)		
5. Have you had, within the last 10 years, any diagnosis of or treatment of:		
a. Disease of heart, blood or blood vessels; high blood pressure, or has heart or blood pressure medication been advised or taken?		
(1) Rheumatic fever or heart murmur?		
(2) Coronary artery disease, chest pain or discomfort?		
(3) Shortness of breath, abnormal heart rate or rhythm?		
b. Disease or disorder of the nose, sinuses, throat?		
c. Disease or disorder of lungs or bronchi?		
(1) Tuberculosis or exposure to tuberculosis?		
(2) Pleurisy, chronic cough or asthma?		
(3) Emphysema or chronic bronchitis?		
d. Disease or disorder of esophagus, stomach, intestinal tract?		
(1) Indigestion, diarrhea, abdominal pain, ulcer, intestinal bleeding or hemorrhoids?		
(2) Jaundice, liver or gall bladder diseases?		
e. Disease or disorder of kidneys, uterus, bladder? Sugar, albumin, pus, blood or casts in the urine?		
(1) Disease or disorder of prostate or testicles?		
(2) Disease or disorder of breasts, uterus, tubes, ovaries, abnormal menstruation or pregnancies: present pregnancy?		
f. Disease or disorder of brain or nervous system?		
(1) Headache, dizziness or unconsciousness?		
(2) Convulsion, epilepsy, paralysis?		
(3) Neuralgia or neuritis?		
(4) Mental illness, depression, anxiety?		
g. Diabetes; thyroid or other glandular disorder?		
h. Unexplained weight loss, recurrent fever, Epstein-Barr virus or chronic diarrhea?		
i. Lymphadenopathy or enlarged lymph nodes?		
j. Disorder of the skin, lymph glands, muscles, bones or joints: arthritis; gout; back disorder?		
k. Disease or disorder of eye or ear; impaired sight or hearing?		
l. Tumor, cancer, or syphillis?		
6. Have you ever had:		
a. AIDS or AIDS Related Complex (ARC), including testing positive for the HIV virus?		
b. Treatment by a member of the medical profession for alcohol or drug use?		
c. Any condition or treatment not specified above necessitating X-rays, electrocardiograms, operations, hospital confinement or examinations or treatment by any physician, practioner, hospital, clinic or institution?		
d. Military service rejection or discharge for medical reasons?		
e. A history in your parents, brothers or sisters of having Diabetes, heart or kidney disease, high blood pressure?		
7. Have you used tobacco in any form in the last 12 months?		

Date last seen:	Reason:

PLEASE GIVE FULL DETAILS FOR ANY "YES" ANSWERS. List dates, duration, dosage, diagnosis, drug, and doctor. (Include full doctor's address, name and phone number.)

8. Family Information	Age If Living	Age At Death	Cause of Death
Father			
Mother			
Brothers			
Sisters			

The answers provided above are true and complete. I understand that the answers and statements in my original application and in this Part II of my application, will be the basis for any insurance issued.

Signature of Medical Examiner

Signature of Proposed Insured

Date

EXAMINATION OF:
(Print full name)

MEDICAL EXAMINATION REPORT - Part III
PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN DETAILS SPACE BELOW.

9. Height		10. Weight		11 & 12 -- For MALES Only		
Feet	Inches	Present	1 Yr. Ago	11. Circumference - Chest		12. Circumf. - Abdomen
				Insp.	Exp.	
14. Pulse Rate		(1)		(2)		(3)
15. Blood Pressure:		Systolic		Diastolic (Phase V)		
1st Reading						
2nd Reading						
3rd Reading						

13. Urinalysis	Albumin	Sugar

	Yes	No
a. Are you satisfied specimen is authentic?		
b. Are you forwarding specimen?		
c. Have you completed with this exam:		
An EKG?		
Blood Profile?		
Other? _____		

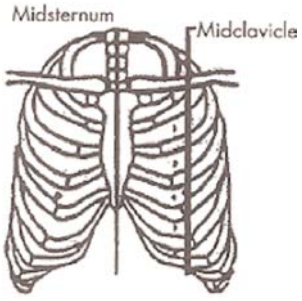
TO BE COMPLETED BY MD ONLY:

Details to Adverse Findings on Part III.

On Inquiry and examination is there evidence of:	Yes	No
16. Present or past diseases or abnormalities of:		
a. Brain, nervous system? (test reflexes; coordination)		
b. Eye, ears, nose, throat, teeth, gums?		
c. Thyroid or lymph glands?		
d. Lungs or respiratory system?		
e. Abdominal organs?		
f. Genito-urinary systems?		
g. Skin or skeletal structure?		
17. Hernia? (If "Yes," describe)		
18. Varicose veins or ulcers?		
19. Arteriosclerosis; other peripheral vascular disease?		
20. Presence of past diseases or abnormalities of heart or blood vessels? (If "Yes," complete questions 21a through g.)		
21. a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?		
b. Is there hypertrophy? (If "Yes," state degree)		
c. Is there a murmur?		
Type: ☐ Systolic ☐ Diastolic ☐ Presystolic Quality: ☐ Soft ☐ Rough ☐ Blowing Intensity: ☐ Faint ☐ Moderate ☐ Loud Location: ☐ Apex ☐ Aortic ☐ Pulmonic		
d. Is murmur constant?		
e. Is murmur transmitted?		
"Yes," where? _____		

f. EXERCISE TEST - 50 vigorous hops	Pulse Rate	Irregularities	Murmur	
		No. per minute	Present	Absent
Before exercise				
Immediately after				
3 minutes after				

g. PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:
Position of apex beat.....
(_____ ins. or _____ cms. from midsternum in _____ interspace)
Murmur:
Area of distribution..... ☐
Point of greatest intensity..... o
Direction of transmission..... >



Name of Agent: _____ District No: _____ Agency No: _____

THIS EXAMINATION MUST BEAR THE DATE AND TIME OF DAY ACTUALLY BEGUN.

I certify that the above is a record of a careful examination of _____

made at (circle one) my office, his/her place of business, his/her home at _____ A.M./P.M. on _____ year ____ .

Signature of Medical Examiner: _____

Address: _____ City: _____ State: _____ Zip: _____