THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

MEDICAL EXAMINATION INSTRUCTIONS

Please read carefully before beginning the Examination.

Instructions
Complete the Medical History Questionnaire (form 90-4) and the Medical Examination (form 90-4B) in their entirety. For any explanation where additional space is required, use the page entitled "MEDICAL HISTORY QUESTIONNAIRE-Additional Details." The Insured and examiner must sign the page, and the city, state, and date of completion must be filled in.

Licensed MD or DO
To perform this examination you must:

- have a medical license in good standing from the state where this exam is being performed, and
- maintain malpractice/professional liability insurance in an amount no less than that required by statute and/or regulation in the state where this exam is being performed, or $1,000,000 per occurrence and $3,000,000 in the aggregate per year, whichever is greater;
- maintain general liability insurance in an amount no less than $1,000,000 per occurrence and $2,000,000 in the aggregate per year, and
- be a Doctor of Medicine or Doctor of Osteopathy and a Board candidate or Board certified in Internal Medicine, Family Practice, Emergency Medicine, Occupational Medicine, Preventive Medicine, or Pediatrics.

Personal, Business or Professional Relationships
This examination should not be performed if you:

- are related to or have a personal, professional or business relationship with the person to be examined or the Northwestern Mutual Financial Representative (Agent), or
- have any business association with a Northwestern Mutual Network Office.

Non-English Speaking Insureds
All examinations must be recorded in English and performed within U.S. borders. Financial Representatives, Associate Financial Representatives, Network Office staff, Insured's or Financial Representative's family members, business associates, or legal representatives may not be present or used to translate any part of the examination.

- If the Insured does not speak English and you are fluent in his or her spoken language, you may proceed with the examination.
- If you are **not** fluent in the Insured's spoken language, prior to initiating the exam, call the phone number the Financial Representative has provided to use a Northwestern Mutual authorized interpreter.
- If the Financial Representative has not provided the telephone number to call for a Northwestern Mutual authorized interpreter, do not perform the exam. Contact the Financial Representative.

Identification
If the Insured cannot or will not provide proper picture or other verification of his/her identity, e.g., driver's license, please do not perform the exam. Contact the Financial Representative.

Complete All Exams in Private
Examinations need to be completed in private. No one other than the Insured may be present during this exam. If the Insured requests a gender specific examiner, nurse or medical assistant, one should be provided. If the Insured is a minor (17 years old or younger), a parent/legal guardian must be present.

Complete History and Exam
Legibly record all answers in your own handwriting using a pen (blue or black ink). All questions are to be read by you to the Insured. If the Insured refuses to answer a question or refuses any part of the exam, indicate this on the examination form. Do not write "deferred" for any response. If any part of the history or examination cannot be completed adequately, the reason should be indicated on the last page of the examination form. Report any other health information obtained during the examination process even though such information may not have been specifically required.

Sensitive Information
Any particularly sensitive confidential information which you believe should be sent directly to the home office may be included in the Medical Examiner's Additional Remarks Section on the exam. Detach and mail directly to: Medical Director, Northwestern Mutual, P.O. Box 2950, Milwaukee, WI 53201-2950.

Alterations
All alterations on the Medical History Questionnaire (form 90-4) must be initialed by the Insured for legal purposes. Your alterations on the Medical Examination (form 90-4B) should be initialed by you.

No Financial Representative Influence
The Financial Representative may not proof, edit, rewrite, influence or discuss any part of the exam or medical history with the Insured, parent/legal guardian, your technician, or you at any time. Such activity should be reported to the Manager of New Business Requirements at the Northwestern Mutual home office at (414) 271-1444.

Property of The Northwestern Mutual Home Office
This examination form, and all information collected in connection with the completion thereof, along with any diagnostic studies (i.e., EKG, Chest X-rays, etc.), are the property of the Northwestern Mutual home office and may not be (1) used by you for any purpose other than the requested review, or (2) disclosed to any third party without prior written consent from the Director – Underwriting Requirements, Northwestern Mutual, P.O. Box 2950, Milwaukee, WI 53201-2950. All completed examinations and studies must be forwarded to the Northwestern Mutual Financial Representative, Network Office or home office. If incomplete, send directly to: Director – Underwriting Requirements. Please notify Northwestern Mutual promptly in the event of any theft, loss, or misplacement of confidential information, in whatever form.

The home office address is: New Business Department, Northwestern Mutual, 720 E. Wisconsin Avenue, Milwaukee, Wisconsin 53202.

Blood/Urine Collection
Specimen collection kits will be provided by the Paramedical Corporate Office (or the Financial Representative if you are not affiliated with a Paramedical Company). Specimens must be sent to the designated Northwestern Mutual laboratory. Instructions for collection are contained within the kits. The Paramedical Company name must be clearly marked on the Laboratory Consent form.

A state specific HIV consent form, if required, must be completed before the blood is drawn. Lab consent form must be signed prior to blood or urine collection. If the Insured will not sign the lab consent form and/or state specific HIV consent form, or if the insured alters either the lab consent form or state specific HIV consent form in any way, do not collect blood or urine specimens. Do not send specimens to the lab. Contact the Financial Representative.

Examiner should record only the last four digits of the insured's social security number on the lab consent form and the medical exam form.

Cardiovascular Studies and Chest X-ray Studies (PA and lateral views)
Requests for cardiovascular (EKG, Treadmill) and Chest X-ray studies will be communicated by either the Financial Representative or Paramedical Company. Forward the following with the exam as directed by the Paramedical company or the Northwestern Mutual Financial Representative: EKG – tracing only; Treadmill - all original tracings and report; Chest X-rays – PA and lateral films/CD and interpretation; to the Paramedical Office, Northwestern Mutual Financial Representative, Network Office or home office. If sending Chest X-rays, use a ground carrier utilizing a tracking number (such as UPS, Airborne Express, etc.). If sent to the home office, send directly to: New Business/Medical Studies, Northwestern Mutual, 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202. If you have questions or need guidelines to complete these studies, contact your Paramedical Corporate Office, (or if you are not affiliated with a paramedical company, the Northwestern Mutual home office, Medical Studies Division, at (414) 665-7379).

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202

MEDICAL HISTORY QUESTIONNAIRE

INSURED NAME (Print the name in this format: First Name, M.I., Last Name)

Each question must be individually asked and answered. For questions 3 – 12, use the DETAILS section to explain all "Yes" responses. Specify the question number and provide relevant details.

1. Do you have a regular or personal physician, doctor, or healthcare provider? ☐ Yes ☐ No

If "Yes," complete the **Current Provider** information in the table below. If you have been seeing your current provider for less than 2 years, complete both the **Current Provider** and the **Previous Provider** information.

PROVIDER	NAME AND ADDRESS	DATE LAST SEEN	REASON FOR LAST VISIT	# OF VISITS IN LAST 12 MONTHS
Current				
Previous				

2. In the last 5 years, have you used tobacco, any other type of product containing nicotine, or a smoking cessation medication? If "Yes," indicate type of product below *(include smoking cessation medication in "Other")*: ☐ Yes ☐ No

- ☐ Cigarettes - Date last used: _____ (MM/DD/YYYY)
- ☐ Nicotine patch or gum - Date last used: _____ (MM/DD/YYYY)
- ☐ Chew or snuff - Date last used: _____ (MM/DD/YYYY) Frequency Used Per Year _____
- ☐ Cigars or pipe - Date last used: _____ (MM/DD/YYYY) Frequency Used Per Year _____
- ☐ Other _____ - Date last used: _____ (MM/DD/YYYY) Frequency Used Per Year _____

3. In the last 10 years, have you been told you had, been diagnosed with, or treated for **any** of the following by a medical professional:

a) High blood pressure or high cholesterol levels? ☐ Yes ☐ No

b) Temporomandibular joint (TMJ) syndrome or any other disease or disorder of the eyes, ears, nose, sinuses, mouth, throat, or speech? ☐ Yes ☐ No

c) Dizziness, vertigo, imbalance, seizure, epilepsy, loss of consciousness, muscle weakness or paralysis, neuropathy, difficulty walking, memory loss or impairment, tremor, headaches, concussion or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

d) Anxiety, depression, stress, bipolar disorder, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), eating disorders or any other psychiatric or mental health disease or disorder? ☐ Yes ☐ No

e) Asthma, emphysema, chronic obstructive pulmonary disease (COPD), wheezing, sleep apnea, sleep disorders, chronic cough, trouble breathing or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No

f) Ulcer, blood in the stool, colitis (including Crohn's disease or ulcerative colitis), irritable bowel, hepatitis, recurrent heartburn, difficulty swallowing, pancreatitis, loss of appetite, recurrent or persistent diarrhea or vomiting, or any other disease or disorder of the esophagus, stomach, intestines, liver, gallbladder, or pancreas? ☐ Yes ☐ No

g) Chest pain/tightness/discomfort, angina, coronary artery disease (CAD), heart attack, heart murmur, heart valve disease, heart failure, irregular heartbeat, stroke, transient ischemic attack (TIA), aneurysm or any other disease or disorder of the heart, blood vessels, or circulatory system? ☐ Yes ☐ No

h) Sugar, blood or protein in the urine, chronic kidney disease (CKD), kidney stone or infection, sexually transmitted disease or any other disease or disorder of the kidney(s), urinary tract, bladder, prostate, reproductive organs, or breasts? ☐ Yes ☐ No

i) Diabetes or elevated blood sugar, thyroid, pituitary, or adrenal disease or any other disease or disorder of the endocrine (glandular) system? ☐ Yes ☐ No

j) Cancer, tumors, masses, cysts, nodules, or polyps? ☐ Yes ☐ No

k) Anemia, bleeding or clotting disorder, recurrent infection, abnormal lymph node(s), allergies, or any disease or disorder of the immune system (except as related to the human immunodeficiency virus or HIV), blood, blood cells, or bone marrow? ☐ Yes ☐ No

l) Arthritis, lupus, fibromyalgia, carpal tunnel syndrome, amputation, or any pain, disease, or disorder of the muscles, bones, joints (including but not limited to the knees and hips), spine, back, neck or extremities? ☐ Yes ☐ No

m) Chronic fatigue syndrome, chronic pain, chronic or unexplained fatigue, malaise or fever of unknown cause? ☐ Yes ☐ No

n) Psoriasis, eczema, atopic or contact dermatitis or any other disease or disorder of the skin? ☐ Yes ☐ No

DETAILS

(1) Signs, symptoms, and diagnosis;
(2) Dates and results of any evaluations, tests, or treatments;
(3) Date of diagnosis, dates/frequency of service/care, and time since last symptoms or time since recovery;
(4) Names, addresses, and telephone numbers of all healthcare providers seen for the disease/condition.
(5) Use the *MHQ Additional Details* (or an additional sheet of paper) for any explanation where additional space is required.

MEDICAL HISTORY QUESTIONNAIRE

4. a) Have you ever sought, received, or been advised to seek treatment, counseling, or participation in a support group for the use of alcohol or drugs? ☐ Yes ☐ No
   b) Have you ever been advised to reduce or discontinue the use of alcohol? ☐ Yes ☐ No
   If "Yes," explain in **DETAILS** section and indicate the average number of drinks (if any) you currently consume per week _____
   c) In the last 10 years, have you used marijuana, cocaine, heroin, methamphetamine, hallucinogens, or any other illegal drug or substance? ☐ Yes ☐ No
   d) In the last 10 years, have you used tranquilizers, sedatives, amphetamines, narcotics, or any other controlled substance other than as prescribed by a physician or in excess of dosages prescribed by a physician? ☐ Yes ☐ No
5. Are you pregnant? If "Yes," what is the due date? _____ ☐ Yes ☐ No
6. Other than as previously stated on the application, in the last 5 years, have you:
   a) Consulted any other healthcare providers (medical doctors, psychiatrists, psychologists, counselors/therapists, chiropractors, naturopaths, occupational/physical/speech therapists or other providers)? ☐ Yes ☐ No
   b) Been a patient in a hospital, clinic, rehabilitation center, or medical facility? ☐ Yes ☐ No
   c) Had any diagnostic or screening tests (EKGs, x-rays, blood tests, CT scans, MRI scans, heart scans, biopsies, or other tests except for human immunodeficiency virus or HIV)? ☐ Yes ☐ No
   d) Had surgery? ☐ Yes ☐ No
   e) Been advised to have any test, consultation, hospitalization, or surgery that was not completed (except as related to the human immunodeficiency virus or HIV)? ☐ Yes ☐ No
7. a) During the last 6 months, have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury? ☐ Yes ☐ No
   b) In the last 5 years, have you requested or received payments, benefits, or a pension because of any injury, accident, sickness, disability, or impairing condition? ☐ Yes ☐ No
8. a) Do you have any immediate family members (including any living or deceased parents and siblings) who were ever diagnosed or treated by any member of the medical profession for heart disease, stroke, diabetes, kidney disease, cancer (e.g., melanoma, breast cancer, or other cancers), or any hereditary disease(s) or condition(s)? If "Yes," list any tests you may have had to evaluate inherited risk in the **DETAILS** section ☐ Yes ☐ No
   b) Please complete 8b even if answer to 8a is "No." Provide the following information about your immediate family members including any conditions from 8a:

FAMILY MEMBER	CURRENT AGE (IF LIVING)	MEDICAL CONDITION(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Sister(s)					
Brother(s)					

9. a) Height: _____ Weight: _____ *(Complete when a paramedical or medical exam is not required.)*
   b) Have you lost more than 10 pounds in the last 6 months? ☐ Yes ☐ No
   If "Yes," indicate the number of pounds lost _____ and explain the reason in **DETAILS** section.
10. Have you ever tested positive for human immunodeficiency virus (HIV), or been diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS)? ☐ Yes ☐ No
11. Other than as previously stated on this application, are you taking any medications or drugs (legal or illegal, prescription or non-prescription/over-the-counter, supplements, or medical marijuana) for any reason? If "Yes," list the medication(s)/drug(s) and the reason(s) for use in the **DETAILS** section ☐ Yes ☐ No
12. If the Insured is 5 years of age or under:
   a) What was the Insured's birth weight? _____ lbs. _____ oz.
   b) Was the Insured born prematurely (gestational age < 37 weeks)? If "Yes," what was the Insured's gestational age (in weeks) at birth _____ ☐ Yes ☐ No
   c) Has the Insured been evaluated, tested, or treated for or diagnosed with developmental delay or disorders, any growth concerns (length/height/weight), or failure to thrive (FTT)? ☐ Yes ☐ No
   d) Has the Insured received or been advised to receive early education services or occupational, physical, speech, or language therapy? ☐ Yes ☐ No

DETAILS

(1) Signs, symptoms, and diagnosis;
(2) Dates and results of any evaluations, tests, or treatments;
(3) Date of diagnosis, dates/frequency of service/care, and time since last symptoms or time since recovery;
(4) Names, addresses, and telephone numbers of all healthcare providers seen for the disease/condition.
(5) Use the *MHQ Additional Details* (or an additional sheet of paper) for any explanation where additional space is required.

SIGNATURE(S)

I have reviewed my answers and statements in this application and declare that they are correctly recorded, complete, and true to the best of my knowledge and belief. Statements in this application are representations and not warranties.

_____ Signature of **INSURED** (or Parent/Guardian)

_____ Signature of: ☐ **LICENSED AGENT** (Include agent #) – non exam ☐ **PARAMEDICAL EXAMINER** – paramedical exam ☐ **MEDICAL EXAMINER** – medical exam

_____ Signed by **INSURED** at CITY and STATE

_____ **DATE** (MM/DD/YYYY)

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

MEDICAL HISTORY QUESTIONNAIRE – *Additional Details*
Supplement to Application

INSURED NAME (First, Middle Initial, Last) PRINT NAME

Use for any explanation where additional space is required.

Question #	Details

I have reviewed my answers and statements on this Supplement and declare that they are correctly recorded, complete and true to the best of my knowledge and belief. Statements on this Supplement are representations and not warranties. This Supplement shall be attached and made part of the application.

Signature of **INSURED** (or Parent/Guardian)

Signature of: [ ] **LICENSED AGENT** (include agent #) - non exam
[ ] **PARAMEDICAL EXAMINER** – paramedical exam
[ ] **MEDICAL EXAMINER** – medical exam

Signed by **INSURED** at CITY and STATE

DATE (MM/DD/YYYY)

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

MEDICAL EXAMINATION

INSURED NAME (First, Middle Initial, Last) PRINT NAME	INSURED PHONE NUMBER ( )	☐ FEMALE ☐ MALE

DRIVER'S LICENSE NUMBER	DRIVER'S LICENSE STATE	WAS A PICTURE ID SHOWN FOR VERIFICATION? ☐ YES ☐ NO	SOCIAL SECURITY NUMBER XXX-XX- *ONLY RECORD LAST 4 DIGITS*

AMOUNT APPLIED FOR $	OCCUPATION	DATE OF BIRTH *(MM / DD / YYYY)*

1. A. HEIGHT *(WITHOUT SHOES) (PHYSICALLY MEASURE)* _____ FT _____ IN

B. WEIGHT *(CLOTHED, WITHOUT SHOES) (PHYSICALLY WEIGH)* _____ LBS.

2. BLOOD PRESSURE *(NOT REQUIRED UNDER AGE 10)*
Take three readings at rest while seated.
SYSTOLIC/DIASTOLIC ____/____ ____/____ ____/____

CUFF SIZE ☐ Regular ☐ Large ☐ Other _____

3. PULSE *(RECORD FOR 1 FULL MINUTE)*
RATE _____ / MIN
IRREGULARITIES / MIN
☐ NONE ☐ YES – IF YES, # IRREGULARITIES PER MINUTE: _____ / MIN

4. IS THE INSURED CURRENTLY MENSTRUATING? ☐ YES ☐ NO (NOTE: If ordered, please collect blood and urine even if menstruating.)

EXAMINATION
PERFORM ONLY WHAT IS REQUESTED ON THE EXAM.

5. On examination is there any abnormality of: *(If yes, give details at right)*

	YES	NO
a. Skin? *(includes scars, suspicious lesions, rashes, etc.)*	☐	☐
b. Eyes? *(include EOM's, pupils, or retinal abnormalities - Note any visual limitations)*	☐	☐
c. Ears/Nose? *(Note any hearing limitations)*	☐	☐
d. Mouth/pharynx?	☐	☐
e. Neck? *(include thyroid, lymph nodes, carotids)*	☐	☐
f. Chest? (*do **not** complete a breast exam - include chest contour and breath sounds)*	☐	☐
g. Heart? *(include PMI - if murmur is present, indicate whether systolic or diastolic, location and intensity)*	☐	☐
h. Nervous System? *(include gait, reflexes, motor, and sensory)*	☐	☐
i. Musculoskeletal? *(include spine, joints, amputations, deformities)*	☐	☐
j. Vascular? *(indicate carotid, radial, popliteal, and pedal pulses - Note the presence of any bruits)*	☐	☐

GIVE DETAILS TO ALL "YES" ANSWERS.
IDENTIFY QUESTION NUMBERS.

COMPLETE MEDICAL EXAMINER QUESTIONS ON PAGE 2

MEDICAL EXAMINATION

INSURED NAME (First, Middle Initial, Last) PRINT NAME

6. ARE YOU AWARE OF ANY ADDITIONAL MEDICAL HISTORY OR OTHER FACTS CONCERNING THE INSURED'S HEALTH, HABITS, ENVIRONMENT, OR OTHER PERSONAL FACTORS WHICH NORTHWESTERN MUTUAL SHOULD HAVE IN EVALUATING THE INSURED? ☐ YES ☐ NO
IF YES, ENTER THESE BELOW. *(FOR PARTICULARLY SENSITIVE INFORMATION, COMPLETE "MEDICAL EXAMINER'S ADDITIONAL REMARKS" FORM AND MAIL AS DIRECTED ON THE FORM.)*

7. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE INSURED?
☐ YES ☐ NO IF YES, EXPLAIN: _____

8. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE FINANCIAL REPRESENTATIVE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

9. ARE YOU CONNECTED WITH A NORTHWESTERN MUTUAL NETWORK OFFICE THROUGH EMPLOYMENT, FAMILY RELATIONSHIP OR OTHERWISE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

10. WAS ANY PORTION OF THE EXAMINATION ASKED OR ANSWERED IN A LANGUAGE OTHER THAN ENGLISH? ☐ YES ☐ NO
IF YES:
WHAT PORTION OF THE EXAMINATION WAS TRANSLATED? _____
IN WHAT LANGUAGE WAS IT TRANSLATED? _____
NAME OF INTERPRETER? _____
INTERPRETER'S COMPANY? _____
RELATIONSHIP OF INTERPRETER TO INSURED? _____ ☐ NO RELATIONSHIP
RELATIONSHIP OF INTERPRETER TO FINANCIAL REPRESENTATIVE? _____ ☐ NO RELATIONSHIP

11. PLACE OF EXAMINATION
☐ MY OFFICE ☐ INSURED'S HOME ☐ INSURED'S PLACE OF BUSINESS ☐ PARAMEDICAL BRANCH OFFICE ☐ OTHER (SPECIFY LOCATION) _____

12. DATE OF EXAMINATION *(MM / DD / YYYY)* | TIME OF EXAMINATION _____ ☐ AM ☐ PM

13. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION

14. THE FOLLOWING SPECIMENS HAVE BEEN COLLECTED AND SENT TO THE AUTHORIZED INSURANCE LAB USING KIT:
☐ BLOOD
☐ URINE
ATTACH BAR CODE HERE FROM LABORATORY CONSENT FORM — BAR CODE

THE FOLLOWING STUDIES ARE ATTACHED TO THE EXAM OR WILL BE SENT TO THE HOME OFFICE:
☐ RESTING EKG *(The Insured's name, date of birth and date of the EKG must be printed on the EKG strip. The Insured must sign and date the EKG.)*
☐ TREADMILL EKG *(All original tracings and report. Report must include Insured name, date of birth, date of study, and reason for stopping, along with description of any symptoms experienced, physician name and signature.)*
☐ PA and LATERAL CHEST X-RAYS *(Deliver as directed by the paramedical company (if applicable), or Financial Representative, or send the films/CD and interpretation via UPS, Airborne Express or Federal Express directly to the home office address on the Instruction page.)*
☐ OTHER *(Specify)* _____

I certify that the above is a record of a careful examination of the Insured and that I completely and correctly recorded the answers on the Medical History Questionnaire (form 90-4) before the Insured signed it. I also certify that I have a medical license in good standing from the state where this exam was performed. I certify that I have complied with all instructions on the Medical Examination Instructions page of this exam form.

_____
MEDICAL EXAMINER NAME *(PRINT OR STAMP)*

♦ _____ MD/DO
SIGNATURE OF MEDICAL EXAMINER

NAME OF FACILITY/PARAMEDICAL COMPANY *(SELECT ONE)*
☐ APPS (AMERICAN PARA PROFESSIONAL SYSTEMS) ☐ EXAMONE ☐ OTHER _____
☐ EMSI (EXAMINATION MANAGEMENT SERVICES, INC.) ☐ PORTAMEDIC

PHONE NUMBER ( )

OFFICE ADDRESS | CITY/STATE/ZIP CODE

MEDICAL EXAMINATION – ADDITIONAL REMARKS

Complete this statement only in situations described below:

(1) If the examination is not completed at the first interview or further observation is indicated.
(2) If further evaluation is recommended.
(3) Any particularly sensitive confidential information to be sent only to the home office (as indicated in the Medical Examination Instructions).
(4) If for any reason you did not complete or refused to perform the examination. Please include the reason why.

INSURED NAME (FIRST, MIDDLE INITIAL, LAST) PRINT NAME		
DATE OF BIRTH (MM / DD / YYYY)	SOCIAL SECURITY NUMBER	RESIDENCE (CITY / STATE)
PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION		

REMARKS

ADDRESS | PHONE NUMBER | MEDICAL EXAMINER NAME (PRINT)

DATE (MM/DD/YYYY) | SIGNATURE OF MEDICAL EXAMINER

MAILING INSTRUCTIONS	
IF...	**THEN...**
Additional remarks are made	• detach this entire page from exam • send to: Medical Director Northwestern Mutual P.O. Box 2950 Milwaukee, WI 53201-2950 • return exam to Financial Representative
No additional remarks are made	• return entire exam to Financial Representative

TO EXPEDITE PAYMENT:

If this service was scheduled through a paramedical company,
please submit your billing information to that paramedical company.

If this service was <u>NOT</u> scheduled through a paramedical company,
please submit an itemized invoice to the address below. Northwestern Mutual reserves the right to withhold payment if any of the following information is not included on the invoice:

- ✓ Northwestern Mutual Financial Representative's full name
- ✓ Insured's name (First, Middle Initial, Last)
- ✓ Insured's date of birth
- ✓ Insured's Social Security Number
- ✓ Date(s) of service
- ✓ Service(s) performed
- ✓ Dollar amount charged for each service
- ✓ Tax Identification Number (Employer Identification Number or Social Security Number) of payment recipient
- ✓ Name of person or entity that check should be made payable to

Failure to provide any of the above information may cause a delay in processing your payment.

Billing address: Requirements Division
Northwestern Mutual
P.O. Box 2950
Milwaukee, WI 53201-2950

The Northwestern Mutual Life Insurance Company
720 East Wisconsin Avenue
Milwaukee, Wisconsin 53202

TEXAS NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above to which you have applied (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 may be released to an insurance medical 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 RESULT

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 the 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 results and explain its meaning.

NAME OF PHYSICIAN FOR REPORTING A POSSIBLE POSITIVE TEST RESULT
ADDRESS OF PHYSICIAN

In the event the test is positive and you are denied coverage because of that fact and you request the reason for 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 collection of a sample 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 further acknowledge receipt of a copy of this form signed by me. A photocopy of this form will be as valid as the original.

SIGNATURE OF PROPOSED INSURED OR PARENT/GUARDIAN _____ DATE SIGNED (MM/DD/YYYY) _____

NAME OF PROPOSED INSURED (PLEASE PRINT) _____ ADDRESS OF THE PROPOSED INSURED _____

SEND ORIGINAL WITH APPLICATION/EXAM — GIVE A COPY TO PROPOSED INSURED
THE HOME OFFICE WILL ACCEPT A FAX TRANSMISSION OF THIS ORIGINAL, SIGNED DOCUMENT