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

Northwestern Long Term Care Insurance Company
P.O. Box 3124
Milwaukee, WI 53201-3124

PHYSICAL MEASUREMENTS EXAMINATION

POLICY NUMBER

☐ LIFE
☐ DI
☐ LTC

INSURED NAME (First, Middle Initial, Last)	INSURED PHONE NUMBER ( )	☐ FEMALE ☐ MALE
DRIVER'S LICENSE NUMBER	DRIVER'S LICENSE STATE	WAS A PICTURE ID SHOWN FOR VERIFICATION? ☐ YES ☐ NO
DATE OF BIRTH *(MM/DD/YYYY)*	SOCIAL SECURITY NUMBER *(LAST 4 DIGITS ONLY)* XXX-XX-	
1. A. HEIGHT *(PHYSICALLY MEASURE, WITHOUT SHOES)* FT IN	B. WEIGHT *(PHYSICALLY WEIGH CLOTHED, WITHOUT SHOES)* LBS	

C. HAVE YOU LOST MORE THAN 10 POUNDS IN THE LAST 6 MONTHS? ..... ☐ YES ☐ NO

IF "YES," INDICATE THE NUMBER OF POUNDS LOST: _____ PROVIDE REASON FOR WEIGHT LOSS:_____

2. BLOOD PRESSURE *(NOT REQUIRED UNDER AGE 10)* Take three readings at rest while seated. SYSTOLIC/DIASTOLIC _____ / _____ _____ / _____ _____ / _____	CUFF SIZE ☐ Regular ☐ Large ☐ Other _____

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

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

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

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

7. DATE OF EXAMINATION *(MM/DD/YYYY)*	TIME OF EXAMINATION ☐ AM ☐ PM

8. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE

9. THE FOLLOWING SPECIMENS HAVE BEEN COLLECTED AND SENT TO THE AUTHORIZED INSURANCE LAB USING KIT. ☐ BLOOD ☐ URINE ☐ SALIVA

ATTACH BAR CODE FROM LAB CONSENT FORM HERE

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.)*
☐ OTHER *(Specify)*_____

I certify that the above is a record of the measurements I completed on the insured and that I completely and accurately recorded the information and answers. I certify that I have complied with all the instructions on the Physical Measurements Examination Instructions page for this examination.

_____
SIGNATURE OF PARAMEDICAL EXAMINER

PARAMEDICAL EXAMINER NAME	PHONE NUMBER ( )	
NAME OF PARAMEDICAL COMPANY *(SELECT ONE)* ☐ APPS (AMERICAN PARA PROFESSIONAL SYSTEMS) ☐ EMSI (EXAMINATION MANAGEMENT SERVICES, INC.) ☐ EXAMONE ☐ PORTAMEDIC	OFFICE ADDRESS	CITY/STATE/ ZIP CODE