The Northwestern Mutual Life Insurance Company
720 EAST WISCONSIN AVENUE, MILWAUKEE, WI 53202

PARAMEDICAL EXAMINATION INSTRUCTIONS

Please read carefully before beginning the Examination.

Instructions	Record all answers in full.
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 advisor) • 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 examination. If the insured requests a gender specific examiner, nurse or medical assistant, one should be provided.
Complete History and Exam	All questions are to be read by you to the insured. Record all answers in full. If the insured refuses to answer a question or refuses any part of the exam, indicate this on the examination form. If any part of the history or examination cannot be completed adequately, the reason should be indicated on the examination form. Report any other health information obtained during the examination process even though such information may not have been specifically required.
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, 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, 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 must be forwarded to the Northwestern Mutual financial representative, within 24 hours of completion of services according to his/her instructions. 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.
Specimen Collection	Specimen collection kits will be provided by the paramedical corporate office and 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/saliva collected. Lab consent form must be signed prior to blood, saliva 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, saliva 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 paramedical exam form.
EKG	Requests for an EKG study will be communicated by either the financial representative or paramedical company. All EKGs for females must be completed by a female paramedical examiner/technician. See the exam form for specific instructions. Attach the EKG tracings to the exam and forward to the Northwestern Mutual financial representative, according to his/her instructions. If you have questions or need complete guidelines for this study, contact your paramedical corporate office.

MEDICAL HISTORY QUESTIONNAIRE

INSURED NAME FIRST	M.I.	LAST

Instructions:

- **As used in this Medical History Questionnaire, the terms "you" and "your" refer to the Insured. The terms "you" and "the Insured" are used interchangeably throughout.**
- **Each question must be individually asked and answered. Use the DETAILS section or Additional Details page to explain all checked boxes (other than "NONE") and all "YES" responses.**

To begin the Medical History Questionnaire, read the '*Declaration of Truth*' with the Insured or Parent/Guardian. They must "Agree" to proceed.

Declaration of Truth: *The responses provided below are complete, accurate, and truthful to the best of my knowledge and belief. I acknowledge that any inaccurate or misleading statements could result in the reformation, rescission or termination of this policy and impact the payment of future claims. Given Northwestern Mutual's status as a mutual company, inaccurate or misleading statements potentially harm other policyholders.*

☐ **Agree**

HEALTHCARE PROVIDERS

1. Do you have a regular physician, doctor or healthcare provider?..... ☐ YES ☐ NO
If "YES," complete the information below on your current physician, doctor or healthcare provider:

NAME		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
WHEN DID YOU LAST SEE THIS MEDICAL PROVIDER? *(MM/YYYY)*	REASON FOR YOUR LAST VISIT?		

2. Have you been receiving care from your regular physician, doctor or healthcare provider for less than two years?..... ☐ YES ☐ NO
If "YES," complete the information below on your former physician, doctor or healthcare provider:

NAME		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
WHEN DID YOU LAST SEE THIS MEDICAL PROVIDER? *(MM/YYYY)*	REASON FOR YOUR LAST VISIT?		

GENERAL INFORMATION

3. Is the Insured over age 5? If "YES," complete A-C below..... ☐ YES ☐ NO

A. Height: _____ ft. _____ in.

B. Weight: _____ lbs.

C. Have you lost more than 10 pounds in the last 6 months?..... ☐ YES ☐ NO
If "YES," how many pounds have you lost? _____
Provide details about the weight change (e.g., intentional through diet and exercise):
_____

4. Are you pregnant? (Females only)..... ☐ YES ☐ NO
If "YES," what is your due date? _____ *(MM/YYYY)*

JUVENILE HEALTH

5. Is Insured age 5 or under? If "YES," complete A-F below..... ☐ YES ☐ NO

A. Height: _____ ft. _____ in.

B. Weight: _____ lbs. _____ oz.

C. Was the Insured born prematurely (gestational age <37 weeks)?..... ☐ YES ☐ NO
If "YES," what was the Insured's gestational age (in weeks) at birth _____

D. Has the Insured been evaluated, tested, diagnosed with, or treated for developmental delay(s) by a medical provider? ☐ YES ☐ NO
If "YES," describe the delay(s): _____

E. Has the Insured been diagnosed with any growth concerns (including length/height, weight, and head circumference) or failure to thrive (FTT) by a medical provider?..... ☐ YES ☐ NO
If "YES," provide birth length and weight: Length _____ ft. _____ in. Weight: _____ lbs. _____ oz.
If "YES" for D and/or E, who was the medical provider seen for this condition (if different than the Insured's regular physician):
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone Number: _____
When did you last see this medical provider? _____ *(MM/YYYY)*

F. Check any of the services the Insured has received or been advised to receive by a medical provider, and if applicable, provide the date service was last received.
☐ N/A ☐ Educational services _____ *(MM/YYYY)* ☐ Occupational therapy _____ *(MM/YYYY)*
☐ Physical therapy _____ *(MM/YYYY)* ☐ Speech/Language therapy _____ *(MM/YYYY)*

DISEASES AND DISORDERS

For each of the categories of Diseases and Disorders throughout question 6, check each box accordingly or check "None." Provide detail for each condition in the "Details" box provided or use the Additional Details page.

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

CARDIOVASCULAR

☐ Aneurysm
☐ Angina
☐ Cardiac bypass surgery
☐ Cardiac stent(s)
☐ Chest Pain/Tightness/Discomfort
☐ Coronary artery disease
☐ Heart attack
☐ Heart failure
☐ Heart murmur
☐ Heart valve disorder
☐ High blood pressure
☐ High cholesterol
☐ Irregular heart beat or heart rhythm disorder
☐ Stroke
☐ Transient Ischemic Attack (TIA)
☐ Any other diseases or disorders of the heart or blood vessels

☐ **NONE**

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis	Evaluations, Tests, Treatments and General Information (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	Physician Information Name, complete address, and telephone numbers of medical providers.

CANCER/GROWTHS

- ☐ Cancer
- ☐ Cysts
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Masses
- ☐ Nodules
- ☐ Polyps
- ☐ Tumors
- ☐ **NONE**

RESPIRATORY

- ☐ Asthma
- ☐ Chronic cough
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema
- ☐ Sinus disorder
- ☐ Sleep apnea
- ☐ Sleep disorder other than sleep apnea
- ☐ Throat disorder
- ☐ Trouble breathing
- ☐ Any other diseases or disorders of the lungs or respiratory system
- ☐ **NONE**

NEUROLOGY

- ☐ Carpal tunnel syndrome
- ☐ Concussion
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Headaches
- ☐ Imbalance
- ☐ Loss of consciousness
- ☐ Memory loss or memory impairment
- ☐ Multiple sclerosis
- ☐ Muscle weakness
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Seizure/Epilepsy
- ☐ Tremor
- ☐ Vertigo
- ☐ Any other diseases or disorders of the brain or nervous system
- ☐ **NONE**

PSYCHIATRIC/MENTAL HEALTH

- ☐ Anxiety
- ☐ Attention deficit/Hyperactivity Disorder (ADD or ADHD)
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Stress
- ☐ Any other diseases or disorders of psychiatric or mental health
- ☐ **NONE**

GASTROINTESTINAL (GI)

- ☐ Barrett's Esophagus
- ☐ Blood in the stool
- ☐ Crohn's disease
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ Irritable bowel syndrome (IBS)
- ☐ Pancreatitis
- ☐ Recurrent heartburn/GERD (Gastroesophageal Reflux Disease)
- ☐ Recurrent or persistent abdominal pain
- ☐ Recurrent or persistent diarrhea
- ☐ Recurrent or persistent vomiting
- ☐ Ulcerative colitis
- ☐ Ulcers
- ☐ Any other diseases or disorders of the esophagus, stomach, intestines, liver, gallbladder or pancreas
- ☐ **NONE**

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	**Date of Diagnosis**	**Evaluations, Tests, Treatments and General Information** (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	**Physician Information** Name, complete address, and telephone numbers of medical providers.

ENDOCRINOLOGY/GLANDULAR

- ☐ Adrenal disorder
- ☐ Diabetes or elevated blood glucose
- ☐ Pituitary disorder
- ☐ Thyroid disorder
- ☐ Any other diseases or disorders of the endocrine/glandular system
- ☐ **NONE**

HEMATOLOGY/IMMUNOLOGY *- Also Addendum H, for ICC states*

- ☐ Allergies
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ Enlarged lymph nodes
- ☐ Recurrent Infection
- ☐ Any other diseases or disorders of the blood, bone marrow or immune system, excluding HIV or AIDS
- ☐ **NONE**

RHEUMATOLOGY

- ☐ Amputation
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Systemic lupus
- ☐ Any disease or disorder of the mouth or jaw
- ☐ Any other disease or disorder of the muscles, bones, joints (including but not limited to the hips, knees, shoulders)
- ☐ Any other diseases or disorders of the spine, neck, back, or extremities
- ☐ **NONE**

GENITOURINARY

- ☐ Blood in the urine
- ☐ Chronic kidney disease
- ☐ Infertility
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Protein in the urine
- ☐ Sexually transmitted diseases, e.g., chlamydia
- ☐ Any other diseases or disorders of the kidneys, urinary tract, bladder, prostate, reproductive organs, or breasts
- ☐ **NONE**

DERMATOLOGY

- ☐ Basal cell cancer
- ☐ Dermatitis
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous cell cancer
- ☐ Any other diseases or disorders of the skin
- ☐ **NONE**

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	**Date of Diagnosis**	**Evaluations, Tests, Treatments and General Information** (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	**Physician Information** Name, complete address, and telephone numbers of medical providers.

OTHER DISEASES OR DISORDERS

- ☐ Chronic fatigue (present 3 months or longer)
- ☐ Chronic Lyme disease (present 3 months or longer)
- ☐ Chronic pain (present 3 months or longer)
- ☐ Ears
- ☐ Eyes
- ☐ Nose
- ☐ Speech

☐ **NONE**

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis	Evaluations, Tests, Treatments and General Information (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	Physician Information Name, complete address, and telephone numbers of medical providers.

7. In the past 10 years, have you ever tested positive for human immunodeficiency virus (HIV), or been diagnosed by a medical provider as being HIV positive, or having acquired immune deficiency syndrome..... ☐ YES ☐ NO

If "YES," provide details: _____

TOBACCO, ALCOHOL AND DRUGS

8. When was the last time you used tobacco or any other nicotine products?

Check the box for any products used.	Date Last Used (MM/YYYY)	Frequency Used Per Year	Never Used
☐ Cigarettes			☐
☐ Cigars			☐
☐ Chew or Snuff			☐
☐ Pipes			☐
☐ Vaping Products			☐
☐ Nicotine Patch			☐
☐ Nicotine Gum			☐
☐ Other _____			☐

9. In the past 10 years**,** have you ever been advised by a medical provider to reduce or discontinue the use of alcohol? If "YES," complete A-B below..... ☐ YES ☐ NO

A. How many drinks, on average, do you consume in a given week?

☐ 0 ☐ 1-14 ☐ 15-21 ☐ 22-28 ☐ 29-35 ☐ 36-42 ☐ 43-49 ☐ 50 or more

B. When did you last drink alcohol? _____ *(MM/YYYY)*

10. In the past 10 years, have you ever received or been advised by a medical provider to seek treatment, counseling or participation in a support group for the use of alcohol or drugs?..... ☐ YES ☐ NO

If "YES," complete A-F below:

A. Was this related to alcohol and/or drug use? ☐ Alcohol ☐ Drugs

B. If drug use, list all types of drugs used: _____

C. When did you last drink alcohol? _____ *(MM/YYYY)* ☐ N/A

D. When did you last use drugs? _____ *(MM/YYYY)* ☐ N/A

E. Indicate if you have received inpatient or outpatient treatment along with duration of care: ☐ N/A

☐ Inpatient _____ *(MM/YYYY)* to _____ *(MM/YYYY)*

☐ Outpatient _____ *(MM/YYYY)* to _____ *(MM/YYYY)*

F. Medical providers, counsellors or facilities seen related to your treatment/counselling:

Name: _____

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

Telephone Number: _____

When did you last see this medical provider? _____ *(MM/YYYY)*

11. In the past 5 years, have you used marijuana? If "YES," complete A-G below..... ☐ YES ☐ NO

A. Indicate the frequency of your use:

☐ Daily ☐ Weekly ☐ Monthly ☐ Annually

B. How many days per: ☐ Week ☐ Month ☐ Year do you use marijuana? _____

C. When did you last use marijuana? _____ *(MM/YYYY)*

D. Is your marijuana use: ☐ Recreational ☐ Medicinal ☐ Both

E. Provide the medical reason for your medical marijuana use: _____

F. Check all boxes that apply concerning the methods that you used or consumed marijuana:

☐ Smoking ☐ Vaporizing ☐ Edible Forms ☐ Other pharmaceutical forms (e.g., pills, oil)

G. Provide name of medical provider (if different from your regular physician) who prescribed medical marijuana:

Name: _____

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

Telephone Number: _____

When did you last see this medical provider? _____ *(MM/YYYY)*

12. In the past 10 years, have you used cocaine, heroin, methamphetamine, hallucinogens, or any other illegal drugs or substance? If "YES," complete A-B below..... ☐ YES ☐ NO

A. Provide details of all illegal drugs/substances used: _____

B. When did you last use any of the listed drugs or substances? _____ *(MM/YYYY)*

13. In the past 5 years, have you used narcotics/opioids, sedatives, amphetamines, or any other controlled substance other than as prescribed by a physician or in excess of dosages prescribed by a physician? If "YES," complete A-B below..... ☐ YES ☐ NO

A. Provide medications or controlled substances used: _____

B. When did you last use any of the listed medications or controlled substances? _____ *(MM/YYYY)*

HEALTHCARE HISTORY

14. In the past 5 years, other than as previously stated on the application, have you**:**
If "YES," to questions A-D, provide details below:

A. Consulted any other medical providers (medical doctors, psychiatrists, psychologists, counselors/therapists, chiropractors, naturopaths, occupational/physical/speech therapists or other healthcare providers)?..... ☐ YES ☐ NO

B. Been a patient in a hospital, clinic, rehabilitation center, or any other medical facility?..... ☐ YES ☐ NO

C. Had any diagnostic or screening tests completed (e.g., EKGs, x-rays, blood tests, CT scans, MRI scans, heart scans, biopsies, or other tests except for Human Immunodeficiency Virus (HIV))?..... ☐ YES ☐ NO

D. Had surgery?..... ☐ YES ☐ NO

DETAILS: Complete for each "YES" answer above. If more space is required, use Additional Details page.

Reason for Consultation, Hospitalization, Surgery or Testing	**Dates of Care or Hospitalization**	**Evaluations, Tests, Treatments** (e.g., details and results of testing or surgery, dates or duration of care)	**Physician Information** Name, complete address, and telephone numbers of medical providers.

E. Been advised by a medical provider to have any test, consultation, hospitalization, or surgery that was not completed (except as related to the Human Immunodeficiency Virus (HIV))?..... ☐ YES ☐ NO

If "YES," provide details of what was recommended and why the recommendation(s) was not completed:

_____

15. 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 or supplements) for any reason?..... ☐ YES ☐ NO

If "YES," list the medication(s)/drug(s) and the reason(s) for use: _____

16. **A.** During the past 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

If "YES," complete 1-4 below:

1. Describe the medical issue(s)/condition(s) that resulted in the work absence or modified work schedule:

_____

2. Describe the extent and duration of the modified work schedule or absence:

_____

3. Have you resumed working your previous schedule and duties? ☐ YES ☐ NO
If "YES," provide date of return: _____ *(MM/YYYY)*

4. Medical provider seen for this issue (if other than your regular physician):
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone Number: _____
When did you last see this medical provider? _____ *(MM/YYYY)*

B. In the past 5 years, have you requested or received payments, benefits, or a pension because of any injury, accident, sickness, disability, or impairing condition? ☐ YES ☐ NO

If "YES," complete 1-4 below:

1. Describe the medical issue(s) that resulted in the payment or request for payment:

_____

2. What type of payment was requested and/or received:

☐ Individual Disability ☐ Group Disability ☐ Social Security Disability ☐ Worker's Compensation
☐ Military Pension ☐ Other _____

3. Are you still receiving a payment? ☐ YES ☐ NO

If "YES," what is the duration of payment (in years)? _____

If "NO," are you still pursuing a payment? ☐ YES ☐ NO

4. Medical provider seen for this issue (if other than your regular physician):

Name: _____

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

Telephone Number: _____

When did you last see this medical provider? _____ *(MM/YYYY)*

FAMILY HEALTH HISTORY

17. A. Do you have any immediate family members (including any living or deceased parents and siblings) who were diagnosed or treated by any medical provider for heart disease, stroke, diabetes, kidney disease, cancer (e.g., melanoma, breast cancer, or other cancers), mental illness, dementia, Huntington's disease, neurofibromatosis, or aneurysm(s)? ☐ YES ☐ NO

B. List any tests below that you may have had to evaluate your risk based on your family history: ☐ N/A

_____

_____

C. Provide the following information about your immediate family members, including any conditions from 17A.

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

SIGNATURE(S)

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.

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)	**DATE** (MM/DD/YYYY)	**STATE** where **INSURED** (or Parent/Guardian) signed
Signature of: ☐ **LICENSED AGENT/FIELD STAFF** – non-exam ☐ **PARAMEDICAL EXAMINER** – paramedical exam	**AGENT/FIELD STAFF #**	Name of **LICENSED AGENT/FIELD STAFF** # (Please print)

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

MEDICAL HISTORY QUESTIONNAIRE

ADDITIONAL DETAILS

INSURED NAME FIRST	M.I.	LAST

Use for any explanation where additional space is required.

Diseases/Disorders or 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 in this Supplement are representations and not warranties. This Supplement shall be attached and made part of the application.

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

DATE (MM/DD/YYYY)

STATE where **INSURED** (or Parent/Guardian) signed

Signature of:

☐ **LICENSED AGENT/FIELD STAFF** – non-exam

☐ **PARAMEDICAL EXAMINER** – paramedical exam

AGENT/FIELD STAFF #

Name of **LICENSED AGENT/FIELD STAFF** # (Please print)

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

PARAMEDICAL 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.)

5. ARE YOU AWARE OF ANY ADDITIONAL MEDICAL HISTORY OR OTHER FACTS CONCERNING THE INSURED?
☐ YES ☐ NO IF YES, NOTE HERE: _____

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

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

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

9. 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

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

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

12. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION

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

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)* _____

BAR CODE

ATTACH BAR CODE HERE FROM LABORATORY CONSENT FORM

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 to the questions on the Medical History Questionnaire (form 90-4) before the Insured signed it. I certify that I have complied with all instructions on the Paramedical Instructions Page of this exam form.

➧ _____
SIGNATURE OF PARAMEDICAL EXAMINER

PARAMEDICAL EXAMINER NAME *(PRINT OR STAMP)*		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