NATIONAL WESTERN LIFE INSURANCE COMPANY

MEDICAL HISTORY – APPLICATION PART II

This Medical History - Application Part II shall amend and be made a part of the undersigned's Application for Insurance to National Western Life Insurance Company, 850 East Anderson Lane, Austin, Texas 78752-1602

Proposed Insured (Photo I.D)			**Birth Date** (Month/Day/Year)	**Age**
First	Middle	Last		

1. When did you last consult a Physician? Date _____ Reason _____

Name of Physician _____ Address _____

2. Name of Family Physician _____ Address _____

3. Family History of Proposed Insured	**Age if Living**	**Age at Death**	**Cause of Death if Deceased or State of Health if Living**		**Number Living**	**Number Deceased**	**Cause of Death if Deceased**
Wife or Husband				Brothers			
Mother				Sisters			
Father							

	YES	**NO**
4. In the last five years has the Proposed Insured used any tobacco or nicotine products, such as smoking cigarettes, pipes or cigars; used snuff, chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge?	❒	❒
If yes, indicate: Type of product _____ Frequency and amount used _____ Month/Year last used _____		
5. Have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:		
A. High blood pressure, stroke, anemia, chest pain, heart attack, disease or disorder of the blood, heart, arteries or veins?	❒	❒
B. Ulcers, or disease or disorder of the stomach, intestines, liver, gallbladder or rectum?	❒	❒
C. Diabetes, cancer, tumors, cysts, leukemia, or disorder of the pancreas, thyroid, adrenal, lymph or other glands?	❒	❒
D. Epilepsy, convulsions, nervous or mental disorder, paralysis, or disorder of the brain or nervous system?	❒	❒
E. Disease of the kidney, bladder, genital organs, or had sugar, albumin, or blood in the urine, or had gonorrhea or syphilis?	❒	❒
F. Asthma, emphysema, tuberculosis, chronic bronchitis, or disease of the lung, chest or throat?	❒	❒
6. Have you lost or gained more than 10 lbs. during the past 12 months?	❒	❒
7. Other than as answered above, have you within the past 5 years:		
A. Consulted a health care provider, or been admitted to a hospital, treatment center, or other facility?	❒	❒
B. Been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS)?	❒	❒
C. Had an X-ray, ECG, blood or urine test, or other diagnostic medical test?	❒	❒
D. Requested or received payments or reimbursements for a mental or physical disability?	❒	❒
E. Been advised to have surgery, hospitalization, treatment, or diagnostic test that has not been completed?	❒	❒
F. Taken medication for any disease, disorder or condition not indicated above?	❒	❒
G. Been treated or counseled by a health care provider for alcohol use or ever used illegal drugs?	❒	❒

PART II DETAILS: Please provide complete details for all "yes" answers above.

Ques. No.	**Reason For Treatment**	**Date**	**Name of Doctor or Hospital And Address**

If more space is needed, use an additional sheet of paper, dated and signed by the proposed insured.

I declare that the answers above are true and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ , 20_____

Witness ✕ _____ M.D. ✓ _____

Signature of Medical Examiner — Signature of Proposed Insured

PHYSICAL EXAM REPORT - PART III

THE PROPOSED INSURED MUST BE IDENTIFIED BY A PHOTO I.D.

1. **A.** Height (In shoes) ..... _____ft. _____in.
   Weight (Clothed) ..... _____lbs.
   Chest (Full Inspiration) Males Only ..... _____in.
   (Forced Expiration) ..... _____in.
   Abdomen, at Umbilicus ..... _____in.
   B. Did you weigh? ..... Yes ❒ No ❒
   Did you measure? ..... Yes ❒ No ❒
   C. Is appearance unhealthy or older than stated age? ..... Yes ❒ No ❒

2. Blood Pressure - *Record 2nd and 3rd readings at intervals during exam if history of hypertension or if 1st reading is 140 systolic or 90 diastolic or greater.

	1st Reading	*2nd Reading	*3rd Reading
Systolic			
Diastolic			
Pulse Rate			
Beat irregularities per min.			

3. Is there on examination any abnormality of the following? (Circle applicable items and give details.)	Yes	No
A. Heart or Blood Vessels (For murmur give location, timing, transmission, your diagnosis, etc. For enlargement or edema, give degree.)	❒	❒
B. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	❒	❒
C. Skin (include scars); lymph nodes, varicose veins or peripheral arteries?	❒	❒
D. Nervous system (include reflexes, gait, paralysis)?	❒	❒
E. Respiratory system?	❒	❒
F. Abdomen (include scars)?	❒	❒
G. Genitourinary system (include prostate)?	❒	❒
H. Endocrine system (include thyroid and breasts)?	❒	❒
I. Musculoskeletal system (include spine, joints, amputations, deformities)?	❒	❒
4. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	❒	❒

5. Urine: (Not required when specimen is sent to insurance company lab.)
   A. Specific Gravity ..... _____
   B. Albumin ..... _____
   C. Sugar ..... _____
   D. Have you sent a specimen to the Insurance Company Laboratory? ..... _____

Ques. No.	Details of "Yes" answers to Questions 1C, 3, 4 and/or 5

I certify that I have carefully examined_____ of _____ and they have been identified by a photo I.D.
(City and State)

How long have you known the proposed insured?_____ Are you related to proposed insured or agent?_____

Examined at: ❒ Office ❒ His place of business ❒ His home this_____ day of _____, 20 ___ at _____ ❒ a.m. ❒ p.m.

Signature of Examiner ✕ _____ Print Examiner Name_____

Examiner Address_____

Medical School_____ Year Graduated_____

Medical Specialty_____ Your Fee for this exam $_____

Agent's Name who authorized exam_____ Examiner's Phone Number_____

Please make sure that this Report is accurately and fully completed. Mail directly to the Medical Director at the Home Office of the Company.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, other health care provider, insurance company or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. National Western or its reinsurers may also release such information to the MIB or to other life and health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. The Medical Information Bureau may furnish directly to National Western or its reinsurers any records or knowledge of me or my health. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photo of this form is valid as the original. I may have a copy of this form upon request.

Signature of Proposed Insured ✓ _____ Date _____ 20 _____