ANSWERS MADE TO THE MEDICAL EXAMINER
In Continuation of and Forming a Part of My Application for Insurance to
NATIONAL FARM LIFE INSURANCE COMPANY
P O BOX 1486 FORT WORTH, TEXAS 76101-1486
(PHONE NO. 800-772-7557)

This Examination must be made in private and answers inserted in Examiner's own HANDWRITING.

PROPOSED INSURED: _____ (First Name) (Middle Initial) (Last Name)

DATE OF BIRTH: _____ (Month) (Day) (Year)

1. a. Name and address of your personal physician (if none, so state): _____

   b. Date and reason last consulted: _____

   c. What treatment was given or medication prescribed? _____

2. Does proposed insured have or had:	YES	NO
a. Tuberculosis, asthma, disease of lungs or respiratory system?	☐	☐
b. High or low blood pressure or disease of heart or circulatory system?	☐	☐
c. Disease or disorder of digestive system (including stomach, liver, intestine, gall bladder, pancreas, or ulcer)?	☐	☐
d. Paralysis, convulsions, disease or disorder of brain or nervous system?	☐	☐
e. Stone, colic, stricture, prostate trouble, or any other genito-urinary disorder?	☐	☐
f. Rheumatism, arthritis, disease or disorder of muscle, bones, or joints?	☐	☐
g. Rupture, syphillis, cancer, diabetes, thyroid, or rectal disorder?	☐	☐
h. Impaired sight or hearing?	☐	☐
i. An acquired immune deficiency disorder (AIDS) or the AIDS-Related Complex (ARC)?	☐	☐
j. Hemophelia, anemia, or any other blood disease or disorder?	☐	☐
k. Any other disease, medical condition, injury, operation, or deformity?	☐	☐
3. Is proposed insured:		
a. Now taking medication prescribed by a physician?		
b. Using, or have ever used narcotics, barbiturates, hallucinatory drugs, illegal drugs, or controlled substances except as prescribed by a physician?	☐	☐
c. Using, or have they used any form of tobacco in the last 12 months?	☐	☐
If "YES," indicate below by checking applicable boxes.		
☐ Cigarettes ☐ Pipe		
☐ Snuff ☐ Cigar		
☐ Chewing Tobacco ☐ Other _____		
d. Using, or have they used alcoholic beverages?	☐	☐
If "YES," Daily ☐ Weekly ☐ or Occasionally ☐		
How many and type of drinks? _____		

4. Has proposed insured:	YES	NO
a. Ever received advice, counseling, or treatment regarding the use of alcohol?	☐	☐
b. Ever consulted, or been treated or examined by a physician, mental health advisor or other medical practitioner in the past 5 years?	☐	☐
c. Ever applied for or received any kind of disability compensation?	☐	☐
d. Ever been declined, postponed, or limited for any life or other insurance or reinstatement?	☐	☐
e. Ever been advised to have surgical operations, x-ray treatments, blood tests, chemotherapy, x-rays, electrocardiograms, or basal metabolism?	☐	☐
f. Ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
g. Ever miscarried, had disease of uterus, ovaries or tubes?	☐	☐
5. Is proposed insured now pregnant?	☐	☐
If "YES," indicate no. of months _____		
6. Has weight of proposed insured changed in the past 12 months? No. of lbs. _____ Gained ☐ Lost ☐		
7. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart disease, kidney disease, mental illness or suicide?	☐	☐

Family Record	Age if Living	Age at Death	State of Health or Cause and Date of Death
Father			
Mother			
Brothers and Sisters			
Living			
Deceased			

AGENT'S NAME:

Details of "Yes" answers. Identify question number, circle applicable items: Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce National Farm Life Insurance Company to issue the policy or contract applied for. I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me or my health to give to National Farm Life Insurance Company, or its reinsurer(s), any such information, all to the extent permitted by law.

Signed at: _____ (City) _____ (State) Date: _____

Witness: _____ (Signature of Medical Examiner)

_____ (Signature of Proposed Insured)
(If proposed insured is under age 18, signature of legal guardian is required)

MEDICAL EXAMINER'S REPORT

To be completed in private by Examiner only.

This Report is Confidential Between Company and Examiner.

Examination of heart and lungs must be with stethoscope against bared skin.

1. GENERAL: (a) How long have you known applicant?		6. REFLEXES: (a) Are knee jerks normal?	☐ YES ☐ NO
(b) Are you related to applicant?	☐ YES ☐ NO	(b) Are pupillary reflexes normal?	☐ YES ☐ NO
(c) Have you ever treated applicant? Give details in space below.	☐ YES ☐ NO	(c) Any evidence of Rhomberg sign?	☐ YES ☐ NO
(d) Does the applicant impress you as being healthy and vigorous?	☐ YES ☐ NO	7. HEART: (a) Any murmur? ☐ YES ☐ NO	Location--Apex Base Rt. Lt.
(e) What is applicants apparent age?			Time--Systolic Diastolic
(f) Are there any physical defects or deformities?	☐ YES ☐ NO	(b) Is murmur transmitted? ☐ YES ☐ NO Direction? (Comment below, effect of exercise)	
(g) Exact weight (with clothes)?	LBS.	(c) Give degree of hypertrophy, if any?	
(h) Did you weigh applicant?	☐ YES ☐ NO	(d) Are the arteries thickened or sclerosed?	
(i) Exact height (with shoes)?	FT. IN.	8. PULSE AND BLOOD PRESSURE:	Before Exercise / After 50 Hops / After 3 Minutes
(j) Did you measure applicant?	☐ YES ☐ NO	(a) Pulse	
(k) Girth of chest?	INSP. EXP.	(b) Number of irregularities or intermittences.	
(l) Girth of abdomen?	IN.	(c) Systolic blood pressure	
(m) What is applicants temperature under tongue?		(d) Diastolic blood pressure FIFTH PHASE	
2. EYES, EARS, NOSE AND THROAT: (a) Are pupils regular and equal?	☐ YES ☐ NO	9. Are you satisfied as to applicant's identity and the substantial correctness of all answers?	☐ YES ☐ NO
(b) Any impairment of vision?	☐ YES ☐ NO	10. Was any third party present at examination?	☐ YES ☐ NO
(c) Any impairment of hearing or ear discharge?	☐ YES ☐ NO	11. Where was exam done?	
(d) Any impairment of nose or throat?	☐ YES ☐ NO	12. Do you have any pertinent information which might affect longevity?	☐ YES ☐ NO
3. LUNGS: Is the respiratory murmur clear and distinct over every part of both lungs?	☐ YES ☐ NO		
4. ABDOMEN: (a) Hernia?	☐ YES ☐ NO		
(b) Any scars?	☐ YES ☐ NO		
(c) Any tenderness?	☐ YES ☐ NO		
5. GLANDS: (a) Any evidence of goiter or toxic symptoms?	☐ YES ☐ NO		
(b) Any evidence of enlarged or abnormal glands?	☐ YES ☐ NO		
(c) Any evidence of other tumor or growth?	☐ YES ☐ NO		

IMPORTANT: A blood profile (including HIV) and Urine Specimen are required for each exam.

Use the LabOne blood kit and urine specimen container. Mail to Shawnee Mission, Kansas.

Details of Questions 1–12:

I have carefully examined _____ Date: _____

Signature of Examiner

Examiner's Address

To insure proper payment of services rendered, please enclose your statement.

NATIONAL FARM LIFE INSURANCE COMPANY
P.O. BOX 1486
FORT WORTH, TEXAS 76101-1486
817-451-9550 800-772-7557

NOTICE AND CONSENT FOR HIV-RELATED BLOOD TESTING

To evaluate your insurability, the insurer named above (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 blood 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 information 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 that 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 result and explain its meaning.

Name of physician for reporting a possible positive test result:

Name: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the 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 representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV Related Blood 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 understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____
Signature of Proposed Insured
or Parent/Guardian

Date Signed: _____

_____
Name of Proposed Insured

_____
Address