MEDEXAM 01

NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 14850 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254

Medical Examiner's Report – Application Part 2

First Name | Middle Name | Last Name | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Policy No./Tracking No.

A. Health History for Proposed Insureds Age 15 and Over

1. In the last 5 years has the Proposed Insured consulted a member of the medical profession or been seen at a medical facility for primary care? ☐ Yes ☐ No
   Name _____
   Address _____ Phone number (_____) _____-_____
   Date of last visit: _____ /_____ /_____ Reason for visit: _____
   Treatment or medication provided: _____
   _____

2. Other than as noted above have you taken any prescribed medication in the past 2 years? ☐ Yes ☐ No (If "Yes", provide reason, name and dosage) _____
   _____

3. In the last 10 years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
   a. High blood pressure, chest pain, murmur, arrhythmia, heart attack, or other heart disorder or disease? ☐ Yes ☐ No
   b. High blood sugar or diabetes? (Including for females gestational diabetes) ☐ Yes ☐ No
   c. Asthma, shortness of breath, COPD, emphysema, or any other lung or respiratory disorder? ☐ Yes ☐ No
   d. Tumor, melanoma, leukemia, lymphoma or any type of cancer? ☐ Yes ☐ No
   e. Multiple sclerosis, seizures, sleep disorder or apnea, intellectual disability, memory loss, loss of consciousness or other neurological disorder? ☐ Yes ☐ No
   f. Pancreatitis, hepatitis, liver or thyroid disorder, anemia or other blood disorder? ☐ Yes ☐ No
   g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? ☐ Yes ☐ No
   h. Kidney disorder, protein or blood in the urine, urinary tract disorder or for males elevated PSA? ☐ Yes ☐ No
   i. Gastric bypass or banding, Colitis, Crohn's, blood in stool, rectal bleeding, intestinal polyps or other intestinal disorder? ☐ Yes ☐ No
   j. Bone, neck or back disorder, chronic pain, arthritis, auto-immune disorder, lupus or other connective tissue or muscle disorder? ☐ Yes ☐ No
   k. Depression, bipolar disorder, anxiety, attention deficit disorder, or other psychiatric or mental health disorder? ☐ Yes ☐ No

4. In the last 10 years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

5. In the last 2 years, other than as already stated, has the Proposed Insured:
   a. Been recommended to have or had surgery? ☐ Yes ☐ No
   b. Been recommended to have or had any diagnostic or routine screening tests (excluding HIV tests)? ☐ Yes ☐ No
   c. Been unable to work, attend school or perform normal activities for 30 days or more? ☐ Yes ☐ No

6. Please provide the Proposed Insured's: Height _____ft. _____in. and Weight _____lbs.

7. In the last 12 months:
   a. Has the Proposed Insured had a change in weight greater than 10 pounds? ☐ Yes ☐ No
   b. If "Yes", please provide how many pounds lost _____ or how many pounds gained _____ and check off all that apply:
      ☐ Diet ☐ Exercise ☐ Surgery ☐ Pregnancy: List actual or anticipated delivery date _____
      ☐ Diagnosed Medical Condition ☐ Medication ☐ Unknown

8. For Proposed Insureds between age 18 and 60: Among the Proposed Insured's natural parents or siblings, has anyone been diagnosed or treated by a member of the medical profession for heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship, medical condition, age at onset of illness, current age if alive, age at death and cause of death. If cancer indicated, provide type or location.). ☐ Yes ☐ No

9. For Proposed Insureds age 70 or over:
   a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No
   b. Does the Proposed Insured live in a facility or receive in-home assistance that provides him or her with personal care? ☐ Yes ☐ No
   c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No
   d. Within the last 2 years, has the Proposed Insured had any falls, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) ☐ Yes ☐ No

MEDEXAM 02

B. Personal Information/Health History for Proposed Insureds Age 14 and Under

1. In the last 5 years has the Proposed Insured consulted a member of the medical profession or been seen at a medical facility for primary care? ☐ Yes ☐ No

   Name _____

   Address _____ Phone number (_____) _____-_____

   Date of last visit: _____ /_____ /_____ Reason for visit: _____

   Treatment or medication provided: _____

   _____

2. Other than as noted above have you taken any prescribed medication in the past 2 years? ☐ Yes ☐ No (If "Yes", provide reason, name and dosage) _____

   _____

3. In the last 5 years, has the proposed insured received vaccinations or are any planned in the next 2 years? ☐ Yes ☐ No

4. In the last 10 years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply and provide details in Section C)
   a. Diabetes, high blood pressure, murmur, or other heart or ciculatory disorder ☐ Yes ☐ No
   b. Asthma, shortness of breath, or any other lung or respiratory disorder? ☐ Yes ☐ No
   c. Tumor or any type of cancer? ☐ Yes ☐ No
   d. Epilepsy, seizures, sleep disorder, developmental delay, intellectual disability, or other neurological disorder? ☐ Yes ☐ No
   e. Any disorder of the liver, pancreas or thyroid? ☐ Yes ☐ No
   f. Anemia or other blood disorder? ☐ Yes ☐ No
   g. Kidney or urinary tract disorder, protein or blood in the urine, or any intestinal disorder? ☐ Yes ☐ No
   h. Arthritis, bone, muscle or connective tissue disorder? ☐ Yes ☐ No
   i. Depression, anxiety, attention deficit hyperactivity disorder (ADHD), or other psychiatric or mental health disorder? ☐ Yes ☐ No

5. In the last 10 years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

6. In the last 2 years, other than as already stated, has the Proposed Insured:
   a. Been recommended to have or had surgery? ☐ Yes ☐ No
   b. Been recommended to have or had any diagnostic tests (excluding HIV tests)? ☐ Yes ☐ No
   c. Been absent from school due to illness for more than 10 consecutive school days or been admitted to a hospital for more than two consecutive days? ☐ Yes ☐ No

7. Please provide the Proposed Insured's: Height _____ft. _____in. and Weight _____lbs.

8. In the last 12 months:
   a. Has the Proposed Insured lost greater than 10 pounds? ☐ Yes ☐ No
   b. If "Yes", please provide how many pounds lost _____ and check off all that apply:
      ☐ Diet or Exercise ☐ Diagnosed Medical Condition ☐ Medication ☐ Unknown

C. Additional Details

For all questions answered "Yes" above provide full details including:

- Question number
- Reason answered "Yes" including diagnosis, treatment, medication, surgery and outcomes
- Date of onset and recovery or current status if condition is still present
- Doctors, hospitals, and facilities information including addresses and phone numbers

Question

_____ _____

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By SIGNING BELOW, I/WE DECLARE THAT, to the best of my/our knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true. I/We also understand that the Insurer will rely upon the answers in this Part II in determining if (and on what basis) life insurance may be issued on the life of the person examined, and that this Part II will be attached to and made part of any such life insurance policy.

Dated at_____ on _____ /_____ /_____ _____

(City, State) (mm/dd/yyyy) Signature of person examined

_____ Witnessed by _____

Signature of Parent or Guardian, if person examined is under age 14 years and 6 months; 15 years in NC; 18 years in PA

* MEDEXAM 04 *

Examiner's Report – Not Part of the Application

*Agent Name*_____
G.O. Code _____ *Agent Code* _____

First Name Middle Name Last Name

1. **Blood Pressure.** Take a second and third reading at the end of the examination; one from each arm. Report all observations. (Do not complete if examinee is under age 12.)

	1st reading	2nd reading	3rd reading
Systolic	_____ mm.	_____ mm.	_____ mm.
Diastolic	_____ mm.	_____ mm.	_____ mm.

2. **Pulse.** (Do not report if examinee is under age 12.)

Pulse rate at rest _____ Per/Min.

Any pulse irregularity? ☐ Yes ☐ No
(If "Yes", obtain EKG and provide details below)

3. Did you measure the height of the examinee? ☐ Yes ☐ No
If "No", provide details below.

4. Did you weigh the examinee? ☐ Yes ☐ No
If "No", provide details below.

5. Did you observe any indication of physical or mental impairment not indicated on the medical form? (If "Yes", provide details below) ☐ Yes ☐ No

6. Are you related to the person examined or has the person ever consulted you for any reason other than an insurance examination? (If "Yes", provide details below) ☐ Yes ☐ No

7. Did the person examined communicate in English well enough to understand and answer the questions on the medical form? ☐ Yes ☐ No
If "No", who acted as interpreter? ☐ Examiner ☐ Agent ☐ Other (Name and relationship to insured. The owner or beneficiary of this insurance may not act as interpreter. A disinterested party must be used.) _____

All specimens are to be sent to lab for analysis.

COMPLETE THIS SECTION *ONLY* FOR A FULL MEDICAL EXAM.

8. **Cardiovascular Examination.**

a. Is there any evidence of cardiovascular disease excluding murmur? (If "Yes", provide details below) ☐ Yes ☐ No

b. Is a murmur present? (If "Yes", complete this section.) ☐ Yes ☐ No

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic
Location: ☐ Apex ☐ Aortic ☐ Pulmonic ☐ Other _____
Transmission: ☐ Axilla ☐ Neck ☐ Precordium ☐ None ☐ Other _____
Intensity: ☐ Soft (Gr. 1-2) ☐ Moderate (Gr. 3-4) ☐ Loud (Gr. 5-6)

Impression: _____

9. **Comments or Details to answers above:**

Ques. No.	Comments or Details
_____	_____
_____	_____
_____	_____
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I CERTIFY that I have carefully examined the person named above and not in the presence of any other person except as stated in the comments section, that I have asked each question exactly as set forth on Page 1 or 2 and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this page, Page 1, 2, and 3, and believe them to be correctly recorded, complete and true.

Print name_____ Examiner ID_____ Signature _____

Name of examining company _____ Date _____ /_____ /_____

Please stamp / provide Social Security No. or Tax ID No. and address. SS # or TIN # _____

Address: Street _____ City_____
State _____ Zip_____ Country_____

TO THE EXAMINER: Any erasures or alterations in this report should be initialed by you. A copy of "answers to the Examiner" (Page 1 and 2) is included in any policy issued; the "examiner's report" (this page) is not included in the policy. If you have any information included above or not shown on this form which you believe should be seen only by Underwriting personnel, please send this report and any confidential information directly to Life Medical Underwriting, New York Life, 51 Madison Avenue, New York, NY 10010.