❒ **The Ohio National Life Insurance Company**
❒ **Ohio National Life Assurance Corporation**

P.O. Box 237
Cincinnati, Ohio 45201

Please print all answers.

Part 2 Paramed Application

1. Print Name of Proposed Insured.

_____

2. When were you last examined for insurance and for what company?

_____

3. a. Name and address of your personal physician? (If none, state "none.")

_____

_____

b. Date and reason last consulted and treatment prescribed.

_____

4. a. Proposed Insured's Family History

		Living		Dead
	Age	**State of Health**	**Age**	**Cause of Death**
Father Mother				
Brothers Sisters				

b. Did either parent, brother or sister ever have cancer or heart disease? ❒ Yes ❒ No
(If "Yes," give details.)_____

Check Applicable Items

		Yes	**No**
5.	In the past 10 years, have you had, or been diagnosed with or been treated for:		
a)	High blood pressure, chest pain or discomfort, heart murmur, palpitations, abnormal pulse, heart attack or any other disorder of the heart or circulatory system?	___	___
b)	Tumor, cyst or cancer including, but not limited to, skin cancer, melanoma or colon polyps?	___	___
c)	A disorder of the blood, spleen or immune system including, but not limited to, anemia, blood clots, bleeding, immune deficiency, leukemia or lymphoma?	___	___
d)	A disorder of the brain, spinal cord or nervous system including seizures, paralysis, vertigo, fainting, headaches, stroke, TIA (transient ischemic attack) dementia, Alzheimer's or amnesia?	___	___
e)	Psychological disorder including, but not limited to, depression, anxiety, bipolar, psychosis, or eating disorder?	___	___
f)	A disorder of the skin, eyes, ears, nose, sinuses, throat or larynx, including, but not limited to, any partial or complete loss of hearing, vision or speech?	___	___
g)	Asthma, bronchitis, emphysema, COPD, sleep apnea, shortness of breath, tuberculosis, allergies, pleurisy or any other disorder of the respiratory system?	___	___
h)	Ulcers, Crohn's disease, colitis, intestinal bleeding, jaundice, hepatitis, diarrhea, diverticulitis, hernia, Barrett's esophagus or any other disorder of the digestive system?	___	___
i)	Gout, arthritis, sciatica, psoriatic arthritis, rheumatoid disorder or any other disorder of the skeletal or muscular system, including amputation of a limb (amputation of fingers included)?	___	___
j)	Diabetes or any disorder of the thyroid, pituitary or adrenal glands?	___	___
k)	A disorder of the kidneys, bladder, prostate or genitourinary organs, including, but not limited to, any findings of blood, sugar or protein in the urine?	___	___
l)	A disorder of the breasts, prostate or reproductive organs, including, but not limited to, sexually transmitted infections?	___	___
m)	Any psychological or physical disorder not listed above?	___	___
6.	Within the past 10 years, have you:		
a)	been treated or advised to seek treatment for drug abuse or alcoholism?	___	___
b)	used marijuana, cocaine, amphetamines, narcotics, anabolic steroids or any controlled substances or habit forming drugs not prescribed by a physician?	___	___
7.	Within the past 5 years, have you received disability benefits, workers' compensation, or a disability pension?	___	___
8.	Have you been diagnosed with or treated by a member of the medical profession as having AIDS, HIV or AIDS Related Complex (ARC)?	___	___
9.	Have you within the past 12 months used any form of nicotine or tobacco products including cigarettes, cigars, chew, electronic cigarettes, gum or patches?	___	___
10.	Have you within the past 5 years, other than noted above:		
a)	had a check-up, consultation, illness, injury or surgery?	___	___
b)	had an EKG, X-Ray or other diagnostic test, excluding an HIV test?	___	___
c)	been a patient in a hospital, clinic, or other medical or mental health facility?	___	___
d)	been advised by a specialist or physician to have surgery, medical treatment or diagnostic testing that has not been completed?	___	___
11.	Are you currently pregnant? (If yes, expected delivery date: _____)	___	___
12.	Are you currently under treatment or taking prescription medications, including medical marijuana?	___	___
13.	Within the last 12 months have you used, or are you currently using, a device that monitors your health, physical exercise, sleep, or other bodily activity?	___	___

Details of "Yes" answers. Identify question number (include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities).
Attach Form 6501 if an additional sheet of paper is necessary.

Authorization

To any physician, practitioner, hospital, clinic or other medical or medically-related facility, health care provider, insurance company or reinsurance company, insurance support organization, the Veterans Administration, MIB, Inc. (Medical Information Bureau), a consumer reporting agency, or employer:

In order to enable Ohio National Life to act upon my application for insurance or to decide if I qualify for benefits or coverage, **I authorize** you to give Ohio National Life (or to its legal representatives) any and all information, records or knowledge which you have about my physical or mental condition. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, and includes information about drugs, substance abuse treatments, alcoholism, HIV, AIDS, sexually transmitted diseases and mental illness. You may also give Ohio National Life any financial, employment or personal information requested for insurance purposes.

I authorize Ohio National Life to release information, including personal health information, to reinsurance companies, to MIB, Inc., or to others who perform business or legal services related to my application or the policy or claim thereunder. I further authorize Ohio National Life, or its reinsurers, to make a brief report of my personal health information to MIB. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

- This authorization is good, as needed, for 24 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I understand that I have the right to receive a copy of this authorization.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

A copy of this exam form will be attached to and made part of the policy issued.

The statements and answers on this Paramed Application Part 2, are true and complete to the best of my knowledge and belief.

Dated _____ at _____ _____
City State Signature of Proposed Insured

Witnessed by _____ _____
(Medical Examiner) Signature of Parent or Guardian if Proposed Insured is a minor

Examiners Report

1a. Proposed Insured's Name

1b. Date of Birth

2. How did you identify the person to be examined?

❒ Drivers License ❒ Other Picture I.D. (Describe): _____ Are you related? ❒ Yes ❒ No

3a. Height (in shoes) ____ ft. ____ in.

3b. Weight (in clothes) _____ lbs.

3c. Measurements

CHEST EXPANDED	CHEST CONTRACTED	WAIST
_____ in.	_____ in.	_____ in.

3d. Has client's weight changed by more than 10 pounds in the past year? ❒ Yes ❒ No

If yes, by how much? _____

4. Blood Pressure

	SYSTOLIC	DIASTOLIC
1ST READING		
2ND READING		
3RD READING		

5. Pulse Rate

❒ Regular
❒ Irregular

6a. Did you:
measure? ❒ Yes ❒ No
weigh? ❒ Yes ❒ No

6b. Is appearance unhealthy or older than stated age? ❒ Yes ❒ No

6c. Are you aware of additional medical history? ❒ Yes ❒ No
(A confidential report may be sent to the Medical Director.)

Details of "Yes" answers in questions **6b** and **6c**.

Examination was made at:
❒ residence ❒ business ❒ my office

TIME ___ :___ ___ o'clock ❒ a.m. ❒ p.m.

DATE

MEDICAL EXAMINER SIGNATURE _____ PRINTED NAME _____

ADDRESS _____

Ohio National Financial Services®

❒ The Ohio National Life Insurance Company
❒ Ohio National Life Assurance Corporation/*Cincinnati*

P.O. Box 237
Cincinnati, Ohio 45201-0237

Please print all answers in ink.

Applicant Name _____ **Policy Number** _____

Additional Information for the Application for coverage on the Applicant and Policy Number named above.

Question Number:

Signature _____ Date _____

Form 6501