Prudential

Statements Relating To Insurability For An Amount Of Group:

Group Policy No(s). _____

☐ Term Life Insurance
☐ Long Term Disability Insurance
☐ Long Term Care Insurance

1. Name (Print) First MI Last	2. Date of Birth Month Day Year	3. Birthplace
4. Address No. Street City State or Province Zip Code		5. Sex ☐ Male ☐ Female
6. Employer's Name	7. Height _____ ft. _____ in.	8. Weight _____ lbs.

9. Have you:	Yes	No
a. been absent from work because of sickness or injury during the last six months?	☐	☐
b. been in any hospital or other institution for observation, rest, diagnosis, or treatment during the past five years?	☐	☐
c. been examined by, or consulted a doctor or other practitioner during the past five years?	☐	☐
d. ever used barbiturates, heroin, opiates, or other narcotics except as prescribed by a physician, or ever been treated for alcoholism?	☐	☐
e. ever been declined or postponed for life or health insurance, or had a policy rated up, waivered, or issued for a smaller amount than applied for?	☐	☐
f. ever applied for or received benefits, compensation, or pension on account of sickness or injury?	☐	☐

10. Have you at any time been treated for or been told you had any trouble with any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart, chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	P. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

11. Have you known indication of any physical disorder, deformity, defect, or abnormality not disclosed in the answers to questions 9 and 10? ☐ ☐

12. What are the complete details of all "Yes" answers to questions 9, 10, and 11, including all conditions, all doctors and all institutions?

Question No.	Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment and medication.	Began Mo. Yr.	Time lost from normal activities	Full recovery Mo. Yr.	(Print) Full names and addresses of doctors and hospitals

I declare that to the best of my knowledge and belief, all of the above answers are complete and true. I agree that the insurance applied for is subject to the policy terms and shall become effective on the date or dates established by the policy, provided the evidence of insurability is satisfactory.

Witness_____ Date_____

Signature of Individual_____

AUTHORIZATION For the Release of Information

To: any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB, Inc. or other organization, institution, or person.

So that eligibility for life or disability coverage can be determined, I authorize you to give The Prudential Insurance Company of America and through it, to its reinsurers and the MIB, Inc. any data or records you may have about me or my mental or physical health. This also applies to any child proposed for coverage in the application.

This authorization is valid until two years after the effective date of any coverage issued in connection with it. A photocopy of this form will be as valid as the original. The person(s) who signed this form have received a copy of the Medical Information Notice. If they wish, they may have a copy of this authorization.

Signature of Employee	Date 20
Signature of Spouse (if to be covered)	Signature(s) of Children over Age 18 (if to be covered)

INSTRUCTIONS TO THE EXAMINING PHYSICIAN – DO NOT DETACH

1. The face and reverse side of this form are to be completed in every case. After the questions have been answered and the examination has been made, this form should be forwarded directly to Prudential, Group Medical Underwriting, P.O. Box 8796, Philadelphia, PA 19176 without delay. This should be done regardless of the condition of the person examined, the inability to complete the form in all details, or the request of anyone to the contrary.
2. URINALYSIS – A portion of the urine you examine should be sent to the designated lab labeled "Prudential Group" when (a) albumin or sugar is found; (b) there is a history of albumin, sugar, pus, casts or blood in the urine or any disease of the genito-urinary organs; (c) the systolic blood pressure is more than 140 mm. Hg., or the diastolic is more than 90, or there is a history of hypertension; or (d) if requested in the medical examination appointment letter.

EXAMINER'S CONFIDENTIAL REPORT

A. Examination was made at
☐ Home ☐ Business ☐ My Office

B. Time of day examined
☐ A.M. ☐ P.M.

C. Is the person examined your patient? ..... ☐ Yes ☐ No
If "Yes" and any information was not disclosed, give details below.

D. HEIGHT — Did you measure? ft. in. ☐ Yes ☐ No

E. WEIGHT (in clothes) — Did you weigh? lbs. ☐ Yes ☐ No

F. BLOOD PRESSURE

	SYSTOLIC	DIASTOLIC Disappearance of sound (5th Point)
1st Reading		
2nd Reading		
3rd Reading		

Record first reading taken. If systolic is over 140 or diastolic over 90, or if definitely overweight, record two or more readings taken at intervals. Send a urine specimen to the designated lab labeled "Prudential Group" in all cases of elevated blood pressure.

G. PULSE

	Pulse Rate per Minute	Premature Contractions No. per Minute
At rest (seated)		
Immediately after exercise (20 body bendings in 60 seconds or equivalent)		
Two minutes after exercise		

(1) If lowest rate exceeds 90, repeat observations later in examination.

(2) Any irregularities other than premature contractions? ☐ Yes ☐ No
If "Yes," describe below.

H. ARE THERE ANY ABNORMALITIES OF: (Record all details below)

1. BLOOD VESSELS (arteriosclerosis, peripheral vascular)? ☐ Yes ☐ No
2. RESPIRATORY ORGANS (including nose, throat, and mouth)? ☐ Yes ☐ No
3. ABDOMINAL ORGANS (including tenderness hernia)? ☐ Yes ☐ No
4. NERVOUS SYSTEM? (Examine eye, patellar and, when indicated, other reflexes) ☐ Yes ☐ No
5. EYES? (If marked refractive error or history of disease or injury, record vision by Snellen Notation in each eye) ☐ Yes ☐ No
6. EARS? (Describe any discharge present or impaired hearing) ☐ Yes ☐ No

Note: Examine heart in upright, recumbent, and left lateral recumbent positions

I. HEART – ANY MURMUR PRESENT? ..... ☐ Yes ☐ No
If "Yes," complete 1, 2, 3, 4, and 5 below: (If more than one murmur, describe second murmur in open space below.)

1. Murmur details -

A.	☐ Apical	☐ Basal	☐ Other
B.	☐ Systolic	☐ Presystolic	☐ Diastolic
C.	☐ Rough	☐ Blowing	☐ Other
D.	☐ Barely Heard - Gr. 1	☐ Mod. - Gr. 3	☐ Very Loud - Gr. 5
		☐ Loud - Gr. 4	☐ Loudest Possible - Gr. 6
	☐ Faint - Gr. 2		
E.	☐ Transmitted	☐ Localized	

2. Effect of body position?

3. a. Is heart enlarged? ..... ☐ Yes ☐ No
b. Any other abnormal cardiac findings? ..... ☐ Yes ☐ No
(If either is "Yes," describe below.)

4. What is your diagnosis or opinion?
Is murmur functional or organic?

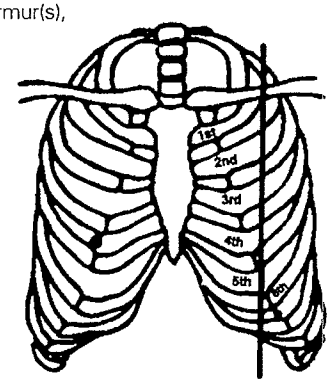
5. Mark position of apex, location of murmur(s), and transmission on diagram.

Position of apex beat X

Area of distribution of murmur ..... ◌

Point of maximum intensity of murmur ..... O

Direction of transmission of murmur ..... ➔



J. ANALYSIS OF URINE

Albumin	Sugar
☐ Yes ☐ No	☐ Yes ☐ No

If either is "Yes," send a portion of the urine examined to the designated lab labeled "Prudential Group"

K. Are you mailing us a urine specimen? ..... ☐ Yes ☐ No

L. Do you have any information about this person not recorded elsewhere on this form relating to physical or mental impairment?
☐ Yes ☐ No

*Please comment on this person's smoking habits/history in the spaces provided below.

GIVE COMPLETE DETAILS OF ALL "YES" ANSWERS TO QUESTIONS G(2), H, I 3a-b, and L

*SMOKING HABITS/HISTORY (if any)_____

The Prudential Insurance Company of America
Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

WE ARE **NOT** REQUESTING AN EKG, CHEST X-RAYOR ANY BLOOD STUDIES

IF URINE SPECIMEN IS REQUIRED (SEE INSTRUCTIONS ON PAGE 1) PLEASE FORWARD IT WITH THE ENCLOSED URINE SPECIMEN LABEL TO THE DESIGNATED LAB.

I CERTIFY that on the date shown I examined the person described herein whose answers to the questions on the reverse were reviewed by me, and that his (her) signature was affixed in my presence.

Medical form received _____ _____ Examining Physician

Date of Examination _____ _____
No. Street City Zone (Canada) State or Province Zip Code (U.S.A.)