TO: ❑ PAN-AMERICAN LIFE INSURANCE COMPANY
❑ PAN-AMERICAN ASSURANCE COMPANY

601 POYDRAS STREET
NEW ORLEANS, LOUISIANA 70130

**Part II of Application** **STATEMENTS MADE BY PROPOSED INSURED TO EXAMINER**
**(Please Print - Indicate name as it appears on the application )**

| 1. a) Last Name of Proposed Insured | First Name(s) | Middle Initial | b) Type of ID and No. | Date of Birth |
|---|---|---|---|---|
| | | | | |

| c) Name of your personal physician or any doctor consulted recently | d) Date and reason treatment last consulted |
|---|---|
| | |

| e) Complete Address (Street & Number, City, State, Zip) | f) Tel. of personal physician | g) E-mail of physician |
|---|---|---|
| | | |

| 2. **To the best of your knowledge and belief, within the last 10 years, have you ever been medically diagnosed with or treated for:** | Yes | No |
|---|---|---|
| a) Disorders of the eyes, glaucoma, cornea. Do not include usual vision correction lenses or routine eye check ups. | ❑ | ❑ |
| b) Disorders of the ears, nose or throat, hoarseness. | ❑ | ❑ |
| c) Seizures, convulsions, stroke, cerebral infarct, TIA, severe migraines, recurrent or unexplained headaches, epilepsy, dizziness, dizzy spells, aneurysm, paralysis, fainting, quadriplegia, mental/nervous disorders or any other disorders of the brain. | ❑ | ❑ |
| d) Pneumonia, bronchitis, asthma, emphysema, allergies, persistent cough, tuberculosis, blood spitting, hemoptisis, chronic respiratory disorder, or any other respiratory or lung disorders. | ❑ | ❑ |
| e) Urinary or genital disorders, kidney stones, renal failure, renal or kidney infections, urinary tract infections, cysts, prostatitis, sexually transmitted diseases. | ❑ | ❑ |
| f) Hepatitis, cirrhosis, gallbladder stones, cholecystectomy, cholecystitis or any other disorders of the liver or gallbladder. | ❑ | ❑ |
| g) Hyperthyroidism, hypothyroidism, thyroiditis, diabetes mellitus type I or II, goiter, hypoglycemia, blood sugar, disorders of the pancreas, parathyroid glands, or endocrine disorders. | ❑ | ❑ |
| h) Benign or malignant tumors, cancer, cysts or lymph gland disorders. | ❑ | ❑ |
| i) Duodenal ulcer, gastric ulcer, dyspepsia, indigestion, gastritis, intestinal bleeding, diverticulitis or diverticulosis, hemorrhoids, colitis, constipation, esophagitis, hiatal hernia, or any other disorders of the digestive system. | ❑ | ❑ |
| j) High blood pressure, myocardial infarction, heart attacks, murmurs, valve lesions, varicose veins, palpitations, tachycardia, chest pain, coronary heart disease, shortness of breath, anemia, rheumatic fever, chagas disease or any other cardiovascular disorder. | ❑ | ❑ |
| k) Arthritis, neuritis, gout, sciatica, rheumatism, or disorders of the muscles, bones, deformity, amputation, spine, back or joints, herniated discs, rheumathoid arthritis, osteoporosis or immune (collagen) diseases. | ❑ | ❑ |
| l) Skin cancer, surgical scars, non surgical scars, other lesions or disorders of the skin. | ❑ | ❑ |
| m) Anemia, leukemia, hemophilia, phlebitis, thrombophlebitis or any disorders of the blood, vascular system or spleen. Received a blood transfusion. | ❑ | ❑ |
| n) Are you currently under observation or treatment by a physician or a medical facility? | ❑ | ❑ |

| 3. Family Record | Age if Living | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers & Sisters<br>No. that are living<br>No. that have died | | | | |

| o) Have been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? | Yes ❑ | No ❑ |
|---|---|---|
| p) Have you been treated for alcohol or drug abuse? | ❑ | ❑ |
| q) Had an EKG, X-Ray, other diagnostic test? | ❑ | ❑ |
| r) Have you within the past five years had a check-up, illness, injury or surgery? | ❑ | ❑ |
| s) Has any immediate family member ever been medically diagnosed with or treated for diabetes, cancer, heart disease, mental illness? | ❑ | ❑ |
| t) **For men over 50 years old:**<br>Have you had a prostate check up.<br>Have you had a PSA test? Indicate dates and results below. | ❑ | ❑ |
| u) **For Women:** | | |
| 1) Disorders of the ovaries, uterus, breast, lumps, abnormal discharge, or any other gynecological or breast disorder? | ❑ | ❑ |
| 2) Have you had a mammogram, PAP smear or gynecological check up recently? Indicate dates, name(s) of physician(s) and results. | ❑ | ❑ |
| 3) Are you pregnant? Indicate how many weeks (or months)? | ❑ | ❑ |
| v) Do you smoke cigarettes, pipe or cigars, or using tobacco in any form? Indicate quantity and frequency. | ❑ | ❑ |
| w) Did you quit smoking? Indicate when: | ❑ | ❑ |
| ❑ 1 yr. ❑ 2 yrs. ❑ 3 yrs. ❑ 10 or more | ❑ | ❑ |

| Quest. No. | Diagnosis and treatment of medical conditions or check ups. Name and address/phone/emails of Doctors or Hospitals | Date |
|---|---|---|
| | | |

*I agree that all the answers to the above questions are true and correct to the best of my knowledge and that they will be part of my application for Insurance.*

| Examiner's Name | Signed at | Date Month | Day | Year |
|---|---|---|---|---|
| | | | | |

**X** _____
Signature of Examiner

**X** _____
Signature of Proposed Insured

## MEDICAL EXAMINER'S REPORT

| 4a.Height (With shoes) | Weight (Clothed) | Men Only: Chest (Full Inspiration) | Chest (Forced Expiration) | Abdomen (At Umbilicus) |
|---|---|---|---|---|
| ft./in. _____ cm. | lbs. _____ kilos | in. _____ cm. | in. _____ cm. | in. _____ cm. |

b. Did you weigh? ❑ Yes ❑ No Did you measure? ❑ Yes ❑ No
c. Is appearance unhealthy or older than stated age? ❑ Yes ❑ No

5. **Blood Pressure** — Register THREE (3) readings at 5 minute intervals

| | | | |
|---|---|---|---|
| Systolic | | | |
| Diastolic (5th. Phase) | | | |

| 6. **Pulse**: | At Rest | After Exercise | 3 Minutes After |
|---|---|---|---|
| Rate | | | |
| Irregularities per minute | | | |

7. a) **Heart**: Indicate if you observed any symptoms of:
Enlargement ❑ Yes ❑ No Dyspnea ❑ Yes ❑ No
Murmur(s) ❑ Yes ❑ No Edema ❑ Yes ❑ No
b) Indicate in detail if any additional studies have been conducted (e.g. Echocardiogram) on the details section

| 8. Is there on examination any abnormality of the following: ..... (Circle applicable items and give details) | Yes | No |
|---|---|---|
| a) Eyes, ears, nose, mouth and pharynx? ..... (If vision or hearing markedly impaired, indicate degree and correction) | ❑ | ❑ |
| b) Skin (including scars); Lymph nodes, varicose veins or peripheral arteries .. | ❑ | ❑ |
| c) Nervous system (including reflexes, gait, paralysis) ..... | ❑ | ❑ |
| d) Respiratory system ..... | | |
| e) Abdomen (include scars) ..... | ❑ | ❑ |
| f) Genitourinary system (including the prostate) ..... | ❑ | ❑ |
| g) Endocrine system (including thyroids and breasts) ..... | ❑ | ❑ |
| h) Musculo-skeletal system (including spine, joints, amputations, deformities) ..... | ❑ | ❑ |
| 9. a) Are there any hernias? ..... | ❑ | ❑ |
| b) Are there any hemorrhoids? ..... | ❑ | ❑ |
| 10. Are you aware of additional medical history? ..... (A confidential report may be sent to the Medical Director) | ❑ | ❑ |

Details for Questions answered Yes (Identify the medical condition)

| 11. a) Is a urine sample being taken ..... | ❑ | ❑ |
|---|---|---|
| b) Is a blood sample being taken ..... | ❑ | ❑ |

} Send to: Lab One Laboratory ❑ (If affirmative, please complete N° 12)

12. Place the bar code sticker from the Lab One Laboratories

**Place bar code sticker here**

**IMPORTANT NOTICE** - This examination must bear the day when it was actually made and under no circumstance any other.

**Do you consider that the Proposed Insured is currently in perfect state of health?** ❑ Yes ❑ No Explain: _____

**Examination in:** ❑ **Medical clinic / Doctor's office** ❑ **Residence of Proposed Insured** ❑ **Place of business of Proposed Insured** } **at** ___ **a.m. p.m. on this** _____ **day of** _____ **20** ____

Name of the person requesting this exam

Name of Examiner (Print, type or rubber stamp)

Address

City, State Zip

Telephone

E-Mail

Examiner's signature

**X** _____

## PATIENT'S AUTHORIZATION TO RELEASE RELEVANT PROFESSIONAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsurance company, the MIB, Inc., ("MIB") or any other organization, institution or person that has records or knowledge of me and my health, or my minor child's health, to provide, inform, release or authorize inspection of any report, declaration, test, diagnosis or medical record to Pan-American Life Insurance Company, Pan-American Assurance Company or to its Reinsurers. I hereby release such doctor, clinic or hospital or member of its professional team of any restriction imposed by the law to release any and all professional medical history that is on its records, to the above mentioned companies. I also understand that the mentioned companies may request that I take certain tests that are considered necessary to underwrite my application for insurance, including but not limited to urinalysis, electrocardiograms, x-rays, blood tests including but not limited to cholesterol, lipids, glucose, liver and renal function tests, and HIV infection. **A photocopy will be as valid as the original.**

_____ Witness

**X** _____ Proposed Insured's signature

_____ Date