

| Proposed Insured Information  |  |  |  |                                      |     |
|---|--|--|--|--------------------------------------|-----|
| Name First  |  | Middle                                 |  | Last                                 |     |
| Address Street  |  | City                                   |  | State                                | Zip |
| Phone #   |  | Date of Birth (mm/dd/yyyy)             |  | Social Security #                    |     |
| Health Information  |  |  |  |                                      |     |
| 1. Measurements   |  |  |  |                                      |     |
| a. Height (in shoes)<br>_____ ft. _____ in.   |  | Weight (clothed)<br>_____ lbs.         |  | <b>MALES ONLY</b>                    |     |
|   |  |  |  |                                      |     |
|   |  | Chest (full inspiration)<br>_____ ins. | Chest (forced inspiration)<br>_____ ins. | Abdomen (at Umbilicus)<br>_____ ins. |     |
| b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>c. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>d. Did weight change more than 10 pounds within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes: <input type="checkbox"/> Gain <input type="checkbox"/> Loss # of lbs _____<br>Reason _____<br>e. If unable to obtain measured height or weight, please provide reason. _____ |  |  |  |                                      |     |
| 2. Blood Pressure – Take in a sitting position, take two additional readings at five minute intervals if more than 140/90, record all readings.<br>Cuff Size: <input type="checkbox"/> Standard <input type="checkbox"/> Large  |  |  |  |                                      |     |
| <b>Systolic</b>   |  |  |  |                                      |     |
| <b>Diastolic</b>  |  |  |  |                                      |     |
| 3. Pulse<br>At Rest: _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular _____  |  |  |  |                                      |     |
| 4. Smoking<br>a. Do you currently use or have you ever used tobacco or products in any form containing nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(e.g. cigarettes, cigars, pipes, chewing tobacco, nicotine gum, nicotine patches, or any other nicotine delivery system)<br>i. Type: _____ ii. Date last used (mm/dd/yyyy): _____  |  |  |  |                                      |     |
| 5. Have any of the following been completed in conjunction with this exam?<br>a. <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> EKG <input type="checkbox"/> Senior Supplement  |  |  |  |                                      |     |
| Examiner Observation and Remarks  |  |  |  |                                      |     |
| 1. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, provide details. _____   |  |  |  |                                      |     |
| 2. Are there any obvious physical abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, provide details. _____   |  |  |  |                                      |     |
| 3. Did anyone assist the Proposed Insured in answering any questions? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, provide details. _____  |  |  |  |                                      |     |
| 4. Was this exam conducted in a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, provide indicated language and provider of Interpretation or Translation Services (Attach Translators Statement).<br>_____   |  |  |  |                                      |     |



The Penn Mutual Life Insurance Company  
The Penn Insurance and Annuity Company

## Third Party Translator's Statement

| Proposed Insured Information |                            |
|------------------------------|----------------------------|
| Name (First, Middle, Last)   | Date of Birth (mm/dd/yyyy) |

| Declarations   |
|--|
| <p>1. I hereby declare to The Penn Mutual Life Insurance Company and/or The Penn Insurance Annuity Company that I have completed an Exam form for the above Proposed Insured because she/he did not have enough knowledge of the English language to complete the Application herself/himself.</p> <p>2. I further declare to The Penn Mutual Life Insurance Company and/or The Penn Insurance Annuity Company that I am neither the Owner nor the Beneficiary of the Life Insurance Policy that is being applied for.</p> <p>3. I am fluent in the native language of the Proposed Insured and qualified to explain the Exam form and understand the Proposed Insured's answers.</p> <p>4. I further declare to The Penn Mutual Life Insurance Company and/or The Penn Insurance and Annuity Company that I fully and clearly explained each item and question on the Exam form to the Proposed Insured before I recorded the Proposed Insured's response and that she/he unequivocally told me that she/he understood each item and question.</p> <p>5. I understand and acknowledge that it is my sole responsibility, at my own expense, to ensure that any and all translations of documents or otherwise into the language of the Proposed Insured are accurate and complete and that The Penn Mutual Life Insurance Company and/or The Penn Insurance and Annuity Company will not bear any liability or responsibility for inaccurate or incomplete translations.</p> <p>6. I understand and acknowledge that I am not in any way acting as an Agent or Employee of The Penn Mutual Life Insurance Company and/or The Penn Insurance and Annuity Company, in the translation of documents or otherwise.</p> <p>7. I have explained to the Proposed Insured that The Penn Mutual Life Insurance Company and/or The Penn Insurance and Annuity Company shall rely upon the answers provided on the Application for Insurance in determining eligibility for the Life Insurance requested.</p> <p>8. I have reviewed and explained this Translator's Statement to the Proposed Insured, and I declare that she/he has clearly and unequivocally told me that she/he understands the content of this Translator's Statement and understands that any misstatement or omission by the Proposed Insured in applying for Life Insurance may result in coverage being denied or rescinded.</p> <p>9. I attest to the best of my knowledge and belief that the signature on the Exam is the Proposed Insured.</p> |

| Translator  |
|---|
| Language Translated _____                         |
| Print Translators Name and Title/Occupation _____ |
| Signature of Translator _____ Date _____          |
| Signature of Proposed Insured _____               |
| Signed at(city/state) _____ Date _____            |

**Examiner Observation and Remarks (continued)**

5. Do you have any pertinent information or observations? ☐ Yes ☐ No

6. Are you related to the Proposed Insured by blood or marriage or do you have a business or professional relationship with the Proposed Insured? ☐ Yes ☐ No

a. If Yes, explain \_\_\_\_\_

**Adviser Information**

Adviser Name

Field Office

**Signatures**

I represent that I have read the above statements and that my answers are full, complete and true to the best of my knowledge and belief and agree that Penn Mutual, believing them to be true, will rely and act upon them.

Signature of Proposed Insured

Date (mm/dd/yyyy)

Name of Examiner (Print)

Address Street

City

State

Zip

Date of Exam (mm/dd/yyyy)

Time of Exam

☐ AM ☐ PM

Place of Exam: ☐ Home ☐ Business ☐ Examiners Office ☐ Other \_\_\_\_\_

Signature of Examiner

Date (mm/dd/yyyy)