MEDICAL EXAMINATION FORM

PART III Examination is to be made in private and findings are to be treated confidentially.
Mail completed examination to **Petersen International Underwriters**, Lloyd's Correspondents,
23929 Valencia Blvd. # 215, Valencia, CA 91355, 1-800-345-8816 ✯ Fax 661 254-0604 ✯E-mail piu@piu.org
In continuation and forming a part of the application for insurance to Certain Underwriters at Lloyd's London

1. PROPOSED INSURED_____ Date of Birth: _____		
2. When did Proposed Insured last consult a physician? Date _____ Doctor/Address: _____ What treatment was given or recommended? _____ _____		**DETAILS OF YES ANSWERS** (Identify Question numbers and circle all applicable items. Include diagnosis, dates, duration, and names and addresses of all physicians and medical facilities).
3. Has any parent, brother, or sister ever had tuberculosis, diabetes, cancer, high blood pressure, heart disease, kidney disease, or mental illness?	☐ Yes ☐ No	
4. Have you within the past five years:		
a. Been examined by or consulted a physician or other practitioner?	☐ Yes ☐ No	
b. Been under the observation or treatment in a hospital, sanitarium or institution?	☐ Yes ☐ No	
c. Had an x-ray, electrocardiogram, blood, urine or other laboratory tests?	☐ Yes ☐ No	
5. Have you ever:		
a. Received benefits or compensation for sickness or injury or had life or disability insurance rated up, modified, rejected, cancelled or not renewed?	☐ Yes ☐ No	
b. Sought advice or treatment for or been arrested for or been addicted to the use of alcohol or drugs?	☐ Yes ☐ No	
c. Had any disease of the reproductive organs, genital organs, breasts, or any amputation or bodily deformity, hernia or rupture, hemorrhoids or varicose veins?	☐ Yes ☐ No	
d. Been advised to have any diagnostic test, hospitalization or surgery, which was not completed?	☐ Yes ☐ No	
6. Have you ever had or been treated for:		
a. Any disease or disorder of the eyes, ears, nose, throat, or thyroid gland?	☐ Yes ☐ No	
b. Any deformity or disorder of the back, spine, muscles, bones or joints?	☐ Yes ☐ No	
c. Any allergies of any sort or disorders of the skin?	☐ Yes ☐ No	
d. Chest pain, heart murmur, high blood pressure, or any other disease or disorder of the heart, circulatory system, blood, or blood vessels?	☐ Yes ☐ No	
e. Peptic ulcer, indigestion, or any disease of the stomach, intestine, gall bladder, liver, pancreas, spleen, or enlarged lymph glands?	☐ Yes ☐ No	
f. Tuberculosis, asthma, pleurisy, or any other disease of the chest or lungs?	☐ Yes ☐ No	
g. Albumin, pus, blood or sugar in urine, urinary stone, or other disease of the kidneys, bladder or prostate?	☐ Yes ☐ No	
h. Severe headaches, fainting spells, dizziness, vertigo, syncope, epilepsy, paralysis, nervousness, mental disorder, or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	
i. Rheumatic or other fever, syphilis, gout, arthritis, goiter, diabetes, cancer, tumor or disorder of the lymph nodes?	☐ Yes ☐ No	
j. AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus) or been told you had AIDS?	☐ Yes ☐ No	
k. Any surgical operation, treatment, or any illness, ailment, abnormality, or injury not mentioned above within the past five years?	☐ Yes ☐ No	
7. Are you now under treatment or taking any prescription drugs?	☐ Yes ☐ No	
8. Are you pregnant? (If "Yes," give date child is expected.)	☐ Yes ☐ No	
9. Are you aware of any other medical information not listed above?	☐ Yes ☐ No	
10. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, abnormality, injury or disease, except as described above? If **No**, please provide details.		☐ Yes ☐ No

I hereby declare that all the statements and answers to the above questions are complete and true to the best of my knowledge and belief, and I agree that the foregoing, together with this declaration shall form a part, designated as **PART III** of the application for insurance.

_____
Signature of Examiner

X _____
Signature of person examined or applicant if child under age 16

Date _____

MEDICAL EXAMINER'S REPORT

Examination is to be made in private and findings are to be treated confidentially.
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23929 Valencia Blvd. # 215, Valencia, CA 91355, 1-800-345-8816 ✯ Fax 661 254-0604 ✯E-mail piu@piu.org

1. a. Name _____
   b. How did you identify the person examined? _____
   c. Have you ever attended this applicant before? ☐ Yes ☐ No

2. a. Age: _____
   b. Are you related to the person examined or the writing representative? ☐ Yes ☐ No

3. a. HEIGHT: In shoes: _____ ft. _____ in. Did you measure? ☐ Yes ☐ No
   b. WEIGHT _____ pounds. Did you weigh? ☐ Yes ☐ No
   c. GIRTH
   Chest at forced inspiration _____ in.
   Chest at forced expiration _____ in.
   Abdomen _____ in.

4. BLOOD PRESSURE

	Systolic	Diastolic	5th Point Disappearance of Sound
1st Reading	_____	_____	
2nd Reading	_____	_____	
3rd Reading	_____	_____	

5. PULSE

	Pulse	Premature Contractions (Count pulse for one full minute)
a. At rest	_____	_____
b. Immediately after exercise	_____	_____
c. Three minutes after exercise	_____	_____

   d. Is arrhythmia present? ☐ Yes ☐ No
   Describe any irregularity: _____

6. URINALYSIS
   Specific Gravity _____ Albumin _____ Test _____ Sugar _____ Test _____
   Mail remainder of specimen to laboratory on all applicants.

7. SMOKING
   Has Proposed Insured smoked cigarettes at any time within the past 12 months? ☐ Yes ☐ No
   Used other tobacco products? *(If "yes," describe)* ☐ Yes ☐ No
   _____

IMPORTANT: Are you sending, or have you arranged to send an
X-RAY, BLOOD PROFILE or ELECTROCARDIOGRAM?

EKG: ☐ Yes ☐ No X-RAY: ☐ Yes ☐ No BLOOD PROFILE: ☐ Yes ☐ No

Examination made at: ☐ My office ☐ Applicant's residence ☐ Applicant's place of business

I CERTIFY that the above and the reverse side are a record of a careful examination on this date of the person described herein whose answers were recorded as given to me, and whose signature on the reverse side was written in my presence.

Date: _____ Time: _____ AM/PM

Please print or stamp your name and address:

Name _____ FAX _____

Address _____

_____
Signature of Examiner