PHOENIX

Phoenix Life Insurance Company and its subsidiaries
PO Box 8027
Boston MA 02266-8027

Application Part II

Examination to be made in private. Please read all questions to applicant. Answers to be recorded in the examiner's own handwriting.

NAME OF PROPOSED INSURED	SEX	DATE OF BIRTH	OCCUPATION

1. Family Record	Age	Health	Age At Death	Cause of Death
Father				
Mother				
Brothers&Sisters No. Living ____ No. Dead ____				

Please Check (✓) Appropriate	Yes	No
2. To your knowledge, have any of your parents, brothers or sisters had diabetes?	☐	☐
3. A. Have you ever been treated for alcoholism or any drug habit?	☐	☐
B. Have you ever used narcotics, barbiturates, amphetamines, hallucinogens or any prescription drug except in accordance with a physician's instructions?	☐	☐
4. Have you sought treatment or consulted a physician for any reason in the last 5 years, including routine examinations or check-ups? (Give full details.)	☐	☐
5. To the best of your knowledge have you ever had, or been told by any physician or other practitioner that you had:		
A. High blood pressure?	☐	☐
B. Pain, pressure, or discomfort in the chest, palpitation, swelling of the ankles, or undue shortness of breath?	☐	☐
C. Heart disease, heart murmur, angina pectoris, or coronary disease?	☐	☐
D. Rheumatic fever, chorea, rheumatism, or arthritis?	☐	☐
E. Pneumonia, pleurisy, asthma, tuberculosis, chronic cough, or any other disease of the lungs?	☐	☐
F. Epilepsy, fainting spells, concussion, skull fracture, severe headaches, dizziness, mental disorder or nervous breakdown?	☐	☐
G. Indigestion, stomach or duodenal ulcer, colitis, or other disease of the intestines or rectum, gall bladder disorder, jaundice, hepatitis, or liver disorder?	☐	☐
H. Kidney disease, nephritis, kidney stone, bladder trouble, or albumin, sugar, pus, or blood in the urine?	☐	☐
I. Disease of the reproductive organs, prostate trouble, abnormal menstruation, complicated pregnancies or disease of the breasts?	☐	☐
J. Diabetes, venereal disease, gout, thyroid disease, enlarged glands, tumor, polyp, cancer or skin disease?	☐	☐
K. Disease or disorder of blood or blood formation?	☐	☐
L. Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or any other immunological disease or disorder?	☐	☐
M. Paralysis, deformity, or any injury or disorder of the muscles, bones, joints, spine or back?	☐	☐
N. Other than above, any physical or mental disorder, operation, or injury within the past 5 years?	☐	☐

6. NAME OF PERSONAL PHYSICIAN (IF NONE, SO STATE) _____

ADDRESS _____

DATE LAST SEEN, REASON AND OUTCOME _____

	YES	NO
7. A. Have you ever had a surgical operation or been a patient in any hospital, sanatorium, or similar institution?	☐	☐
B. Have you had, or been advised to have, any surgical operations, X-rays, electrocardiograms, blood studies, or other tests within the last 5 years?	☐	☐
C. Has a physician ever advised you to diet?	☐	☐
D. Is there any kind of medicine which you take regularly or at frequent intervals?	☐	☐
8. Have you ever applied for or received sickness or accident benefits or a disability pension from any source?	☐	☐
9. A. Have you ever been declined, postponed, rated, or ridered for insurance?	☐	☐
B. Are you negotiating for other insurance? (If "yes" name companies and amounts.)	☐	☐

10. DETAILS of all questions answered "yes." Include **Dates, Names,** and **Addresses** of all doctors consulted, **Duration, Treatment,** and **Results.** Please indicate question # you are responding to:

Question #

_____

_____

_____

_____

_____

_____

The foregoing statements are full, complete, and true to the best of my knowledge and belief.

DATED AT (City and State)	DATE
WITNESS (Examiner)	PROPOSED INSURED (SIGN FULL NAME)

PARAMEDICAL EXAMINATION – Complete questions 1-11.

MEDICAL EXAMINATION BY PHYSICIAN – Complete all questions.

1. How did you identify applicant? ☐ Driver's license (Please provide number and state) _____
☐ Other (Specify) _____

2. Height: ☐ measure ☐ not measured
If not measured, indicate reason below.

3. Weight: ☐ measured ☐ not measured
If not measured, indicate reason below.

4. Change in Weight: Has applicant's weight changed by 10 pounds or more in the past year? ☐ Yes ☐ No
If "yes", how much: _____ pounds ☐ Gain ☐ Loss
Reason for weight change:

5. Pulse Rate: ☐ regular ☐ irregular
If pulse is irregular, give details below.

6. Blood Pressure: If systolic BP above 140 or diastolic BP above 90, record 2 additional BP readings at least 5 minutes apart.

1st BP Reading:	**2nd BP Reading:**	**3rd BP Reading:**

Size of BP cuff used: ☐ Standard cuff ☐ Large cuff ☐ Small cuff

7. Is applicant pregnant? If "yes," please provide due date	☐ Yes ☐ No
8. Does applicant appear unhealthy or older than stated age?	☐ Yes ☐ No
9. Does applicant use a wheelchair, cane, crutches, walker, or any other assistive device for walking?	☐ Yes ☐ No
10. Is there any indication of confusion or forgetfulness?	☐ Yes ☐ No
11. Are you aware of any other information that is pertinent to the applicant's life expectancy?	☐ Yes ☐ No
PHYSICIAN EXAMINATION ONLY:	
12. On examination, is there any abnormality of the following:	
(a) HEENT (include thyroid exam)	☐ Yes ☐ No
(b) CNS (gait, tremor, weakness, paralysis)	☐ Yes ☐ No
(c) Cardiovascular (If abnormal heart sounds or murmurs are present, please describe fully and give your impression. Also check for peripheral edema or any evidence of peripheral vascular disease.)	☐ Yes ☐ No
(d) Respiratory (breath sounds, wheezing, rales)	☐ Yes ☐ No
(e) Abdomen (surgical scars, ascites)	☐ Yes ☐ No
(f) Musculoskeletal (joints, amputations, deformities	☐ Yes ☐ No
(g) Lymph nodes	☐ Yes ☐ No
(h) Skin (surgical scars, rash, or any possibly significant skin lesions)	☐ Yes ☐ No

Please provide details of any "YES" answers, abnormal findings, or additional remarks:

TESTING PERFORMED IN CONJUNCTION WITH THIS EXAMINATION:

☐ Blood sample
☐ Urine specimen (if female applicant currently menstruating, check here ☐)
Which lab was SMAC/SPEC sent to?_____
☐ Electrocardiogram
☐ Chest X-ray

EXAMINER'S STATEMENT:

I certify that I have carefully examined _____ and that the applicant's responses to all questions on both sides of this form are accurately recorded. (print name of person examined)

Examiner's Signature	Date of Examination / Time of Examination ☐ AM ☐ PM
Examiner's Tax ID Number	Name of Producer Requesting Examination
Examiner's Printed Name	Producer & Agency Code
Examiner's Address	Place of Examination (City, State) ☐ Examiner's office ☐ Applicant's business ☐ Applicant's residence