Part II of my application for Insurance to:

The Reliable Life Insurance Company

Home Office: St. Louis, Missouri 63146

The Original Application will be Part I.

Name of Proposed Insured	Birth Date	Sex	Source of Identification (Picture I.D. only) ☐ Driver's License ☐ State I.D. Card ☐ Other:

Social Security Number:	Driver's License Number:	State of Issue	Amount Applied for:	Name, Address and Phone Number of Personal Physician (If none, so state):

MEDICAL HISTORY (to be recorded by medical examiner):	Yes	No
So far as you know and believe —		
1. Have you ever had any physical disability or impairment?		
2. Is your health impaired at present?		
3. Have you had a weight gain ☐ or loss ☐ in past year? (If "Yes," how much?)		
4. Is any medication being taken? (If "Yes," what?)		
5. Have you had, within the last 10 years, any diagnosis of or treatment of:		
a. Disease of heart, blood or blood vessels; high blood pressure, or has heart or blood pressure medication been advised or taken?		
(1) Rheumatic fever or heart murmur?		
(2) Coronary artery disease, chest pain or discomfort?		
(3) Shortness of breath, abnormal heart rate or rhythm?		
b. Disease or disorder of the nose, sinuses, throat?		
c. Disease or disorder of lungs or bronchi?		
(1) Tuberculosis or exposure to tuberculosis?		
(2) Pleurisy, chronic cough or asthma?		
(3) Emphysema or chronic bronchitis?		
d. Disease or disorder of esophagus, stomach, intestinal tract?		
(1) Indigestion, diarrhea, abdominal pain, ulcer, intestinal bleeding or hemorrhoids?		
(2) Jaundice, liver or gall bladder diseases?		
e. Disease or disorder of kidneys, uterus, bladder? Sugar, albumin, pus, blood or casts in the urine?		
(1) Disease or disorder of prostate or testicles?		
(2) Disease or disorder of breasts, uterus, tubes, ovaries, abnormal menstruation or pregnancies: present pregnancy?		
f. Disease or disorder of brain or nervous system?		
(1) Headache, dizziness or unconsciousness?		
(2) Convulsion, epilepsy, paralysis?		
(3) Neuralgia or neuritis?		
(4) Mental illness, depression, anxiety?		
g. Diabetes; thyroid or other glandular disorder?		
h. Unexplained weight loss, recurrent fever, Epstein-Barr virus or chronic diarrhea?		
i. Lymphadenopathy or enlarged lymph nodes?		
j. Disorder of the skin, lymph glands, muscles, bones or joints: arthritis; gout; back disorder?		
k. Disease or disorder of eye or ear; impaired sight or hearing?		
l. Tumor, cancer, or syphillis?		
6. Have you ever had:		
a. AIDS or AIDS Related Complex (ARC), including testing positive for the HIV virus		
b. Treatment by a member of the medical profession for alcohol or drug use?		
c. Any condition or treatment not specified above necessitating X-rays, electrocardiograms, operations, hospital confinement or Examinations or treatment by any physician, practioner, hospital, clinic or institution?		
d. Military service rejection or discharge for medical reasons?		
e. A history in your parents, brothers or sisters of having Diabetes, heart or kidney disease, high blood pressure?		
7. Have you used tobacco in any form in the last 12 months?		

Date last seen:	Reason:

PLEASE GIVE FULL DETAILS FOR ANY "YES" ANSWERS. List dates, duration, dosage, diagnosis, drug, and doctor. (Include full doctor's address, name and phone number.)

8. Family Information	Age If Living	Age At Death	Cause of Death
Father			
Mother			
Brothers			
Sisters			

The answers provided above are true and complete. I understand that the answers and statements in my application, will be the basis for any insurance issued.

Signature of Medical Examiner

Signature of Proposed Insured

Date

EXAMINATION OF:
(Print full name)

MEDICAL EXAMINATION REPORT - Part III
PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN DETAILS SPACE BELOW.

9. Height		10. Weight		11. & 12 For MALE Only		
Feet	Inches	Present	1 Yr. Ago	11. Circumference - Chest		12. Circumf. - Abdomen
				Insp.	Exp.	
14. Pulse Rate		(1)		(2)		(3)
15. Blood Pressure:		Systolic		Diastolic (Phase V)		
1st Reading						
2nd Reading						
3rd Reading						

13. Urinalysis:	Albumin	Sugar

	Yes	No
a. Are you satisfied specimen is authentic?		
b. Are you forwarding Specimen?		
c. Have you completed with this exam:		
An EKG?		
Blood Profile?		
Other?		

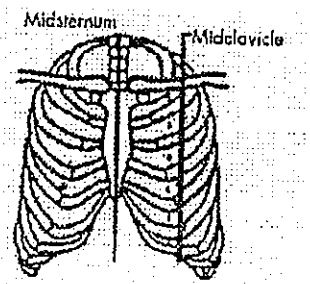
Details to Adverse Findings on Part III

TO BE COMPLETED BY MD ONLY

On inquiry and examination is there evidence of:	Yes	No
16. Present or past diseases or abnormalities of:		
a. Brain, nervous system? (test reflexes; coordination)		
b. Eye, ears, nose, throat, teeth, gums?		
c. Thyroid or lymph glands?		
d. Lungs or respiratory system?		
e. Abdominal organs?		
f. Genito-urinary systems?		
g. Skin or skeletal structure?		
17. Hernia? (If "Yes," describe)		
18. Varicose veins or ulcers?		
19. Arteriosclerosis; other peripheral vascular disease?		
20. Presence of past diseases or abnormalities of heart or blood vessels? (If "Yes," complete questions 21 a through g)		
21. a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?		
b. Is there hypertrophy? (If "Yes," state degree)		
c. Is there a murmur?		
Type: ☐ Systolic ☐ Diastolic ☐ Presystolic		
Quality: ☐ Soft ☐ Rough ☐ Blowing		
Intensity: ☐ Faint ☐ Moderate ☐ Loud		
Location: ☐ Apex ☐ Aortic ☐ Pulmonic		
d. Is murmur constant?		
e. Is murmur transmitted?		
"Yes," where? _____		

f. EXERCISE TEST -	Pulse Rate	Irregularities	Murmur	
50 vigorous hops		No. per minute	Present	Absent
Before exercise				
Immediately after				
3 minutes after				

g. PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:
Position of apex beat.....
(_____ ins. or _____ cms. from midsternum in _____ interspace)
Murmur:
Area of distribution..... ☐
Point of greatest intensity..... o
Direction of transmission..... >



Name of Agent: _____ District No: _____ Agency No: _____

THIS EXAMINATION MUST BEAR THE DATE AND TIME OF DAY ACTUALLY BEGUN.

I certify that the above is a record of a careful examination of _____

made at (circle one) my office, his/her place of business, his/her home at _____ A.M./P.M. on _____ year _____.

Signature of Medical Examiner: _____

Address: _____ City: _____ State: _____ Zip: _____

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THE RELIABLE LIFE INSURANCE COMPANY
12115 LACKLAND ROAD • ST. LOUIS, MISSOURI 63146

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDs, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.
Name of physician for reporting a possible positive test result:

_____
Address:

_____
In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Name of Proposed Insured Signature of Proposed Insured or Parent/Guardian

_____ Date Signed: _____
Address

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