RiverSource Life Insurance Company
70100 Ameriprise Financial Center, Minneapolis, MN 55474

RiverSource Insurance

Insurance Application Medical History — Part II

Proposed Insured's name:

(first) (full middle) (last) Birthdate:

How was the identity of Proposed Insured established? _____ Photo I.D. ☐ Yes ☐ No

1. a. Name and address of your personal physician? (If none, so state) _____
   b. Date and reason last consulted? _____
   c. What treatment was given or medication prescribed? _____

	Yes	No
2. Have you ever had or been treated for:		
a. Disorder of eyes, ears, nose or throat?	☐	☐
b. Multiple sclerosis, Parkinson's disease, dementia, ALS; fainting, convulsions, dizziness; paralysis, memory loss or stroke; mental, nervous, anxiety, depression or emotional condition?	☐	☐
c. Tumor, cancer or lymph node disorder?	☐	☐
d. Persistent hoarseness or cough, shortness of breath, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
e. Congestive heart failure (CHF), cardiomyopathy, chest pain, heart attack, heart palpitation, atrial fibrillation, high blood pressure, rheumatic fever, heart murmur or other disorder of the heart, heart valves, or blood vessels?	☐	☐
f. Liver disorder, yellow jaundice or hepatitis?	☐	☐
g. Stomach or intestinal bleeding, ulcer, colitis, inflammatory bowel disease, diverticulitis, recurrent indigestion, or other disorder of the stomach, pancreas, or intestines?	☐	☐
h. High blood sugar, thyroid disorder or diabetes?	☐	☐
i. Sugar, protein or blood in urine; any disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
j. Arthritis, gout, rheumatism, or lupus; fibromyalgia, chronic fatigue syndrome or other connective tissue disorder?	☐	☐
k. Sciatica, neuropathy, disorder of the muscles or bones, including the spine, back, neck, or joints?	☐	☐
l. Disorder of the skin; allergies?	☐	☐
m. Anemia, bleeding or clotting disorder, or other blood/bone marrow disorder?	☐	☐
n. Excessive use of or dependency on alcohol or drugs, including prescription pain medications?	☐	☐
3. In the last three years, have you been diagnosed or received treatment by a member of the medical profession for AIDS (Acquired Immune Deficiency) or ARC (AIDS-Related Complex), or had a positive HIV test?	☐	☐
4. Have you ever used marijuana, cocaine, heroin, or amphetamines?	☐	☐
5. Have you had any change in weight in the past year?	☐	☐
6. **Other than above,** have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☐
b. Had a checkup, consultation, illness, injury, or surgery?	☐	☐
c. Been a patient in a hospital, clinic or other medical facility?	☐	☐
d. Had an electrocardiogram, treadmill stress test, thallium stress test, angiogram, echocardiogram, MRI or CT scan?	☐	☐
e. Had an x-ray, mammogram, ultrasound, or other diagnostic test?	☐	☐
f. Been advised to have any diagnostic test or surgery which has not been completed?	☐	☐
7. Have you ever used tobacco or nicotine in any form?	☐	☐
a. If yes, what is/was used? _____		
b. What amount? _____		
c. Date last used? _____		
8. Are you currently using any prescription medication? (list medications and reason they are prescribed in **details** section)	☐	☐

Details of "Yes" answers. Identify Question Number: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities. An additional sheet of paper may be attached if necessary.

9. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? ☐ ☐
10. Is there any family history of cancer, diabetes, heart, kidney or neurologic disease? ☐ ☐

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

I have read the statements and answers in this Insurance Application Medical History. I declare to the best of my knowledge and belief, they are complete and true. I understand this Insurance Application Medical History will become part of my application for insurance. It will be attached to and made a part of any policy issued.

Signature of Proposed Insured **Date** **Signature of Witness (Examiner)**

X _____ _____ X _____

Medical Examiner's Report

11. **FOR EXAMINER USE ONLY**

Height_____ feet_____ inches **Weight**_____ lbs.

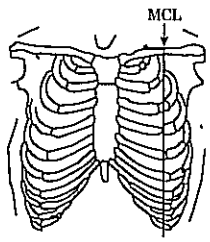
Pulse Rate (1st)_____ Irregularity/ Minute_____ (2nd)_____ Irregularity/ Minute_____

Blood Pressure (Systolic/Diastolic) 1st_____ 2nd_____ 3rd_____

12. Heart: Is there any: _____
Murmur(s) ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No
Edema ☐ Yes ☐ No
(Describe below — if more than one, describe separately)

Location	Apex	Base
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
Thrill	☐	☐

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by O
Transmitted →



Give comments and your impression.

If murmur is present, is it altered by exercise? ☐ Yes ☐ No

13. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx?	☐	☐
b. Skin (incl. scars); lymph nodes; thyroid; or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, atrophy)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Musculoskeletal system (include spine, joints, deformities)?	☐	☐

14. Are you aware of additional medical history? ☐ ☐
(A confidential report may be sent to the Medical Director)

I certify that I have examined the Proposed Insured designated on the reverse side hereof; and that the answers and statements of the Proposed Insured on the Medical History on other side of this sheet are exactly as made by the Proposed Insured to me, and that said Medical History was signed by the Proposed Insured in my presence.

_____
Signature of Medical Examiner

Notice:
RiverSource Life Insurance Company has adopted a "usual, customary, reasonable and prevailing" fee schedule for professional services. Please include a statement indicating your fee for this examination. (Paramedical Examiners: Submit monthly billing.)