

Royal Neighbors of America 230 16th St., Rock Island, IL 61201 Toll-free (800) 627-4762 A Fraternal Benefit Society

Application Part II - Paramedical Exam Form

The following answers and statements are a continuation of and form a part of my application for life insurance to Royal Neighbors of America.

Name of Pro		Date of birth							
If Yes, spe	lost or gained weight during the cify: Pounds lost personal physician/medical facility	Pounds gained	_	treated by a	member betes, cand	of the m	ings decease edical profes ental illness?	si <u>on</u> for h	ne <u>art</u>
complete,	-	Parent or Sibling	Current	Age at death	State of he				
a. Address	and phone number of personal phy	sician/medical facility:	_						
b. List all c	currently prescribed medications,	dosage, and frequency:							
physician physician for the palexcitant, have you virus (Al for the palexcitant) have you virus (Al for the palexcitant) have you can Heart have you can Heart have you day have you have you galexcitant have you galexcitant for Any do galexcitant galexcitant have you have y	ast five years, have you ever receing to discontinue the use of alcohols ast 10 years, have you used amphor hallucinatory drugs, unless adulever been diagnosed by a mem DS virus) or Acquired Immune Defeat five years, have you ever been dispositive for: attack; high blood pressure; strover, tumor, cyst, mass; leukemia; ly tes or other endocrine disorder; sugna; bronchitis; emphysema; pneutinal bleeding; ulcer; hepatitis; or elisease or disorder of the reprodumental, or emotional nervous disorty; or any other disease or disorder itis; loss of limb, or deformity; disted at the disorder; or any other disorder of grests related to Human Immunary surgery or diagnostic test, sugnative disorder to have any diagnostic test, sugnative disorder and results for the reproduction of the presonal physician or medical facility and Address	ol or the use of prescribed or etamines, barbiturates, cocair ministered on the advice of a ber of the medical profession ficiency Syndrome (AIDS)? diagnosed as having, been troke; TIA, cerebrovascular diseasemph gland; thyroid; anemia; cora, albumin, or blood in urine; pronoia; tuberculosis; or any ot other disorder of throat, stome ctive system or breasts?	non-pi ne, nari physic or tes eated l se, or o or any o ancreat her dis nach, live pack, or ? during ray, M or that h	rescribed drug cotics, mariju cian?	gs?	her depre	essant, odeficiency ofession for, ood vessels? prostate? stem? oression; nective dy? or other	Yes	No No No No No No No No
I hereby sta whether wr all of said a Dated at (C	Inte that I am the person named as itten by me or not, and hereby denswers and statements shall be taking and State)	the applicant. I have read all c clare that they are complete a ken as, and be a part of, my sa	of the f and trudaid app , this _	oregoing ans e to the best lication and b day of	wers and s of my kno oe subject	statement wledge a to the ag	ts, adopt thei nd belief. I he reements the	m as my ereby agreerein conf	own, ee that tained.
Witnessed	by(Paramedical Examiner)	Signature of	Propos	sed Insured _					

FRAUD NOTICE/WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.



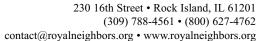
PARAMEDICAL EXAMINER'S REPORT

NOTE: The answers to all questions on this page must be personally written by the Paramedical Examiner.

Please obtain Royal Neighbors of America's signed NOTICE AND CONSENT FOR HIV-RELATED BLOOD TESTING form if required by state

		1st Reading	2nd Reading	3rd Reading	
	Systolic				
	Diastolic				
3. PULS	E (seated)				•
	Rates per minute at	rest			
	Irregularities per mir	ute at rest			
Commen	ts:				







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 the 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 anti-bodies 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 RESULTS

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 cover insurer may require you to name a physician at that tim	age because of that fact and you request the reason for the denial, the e in order to receive the information.
If the test indicates a positive result, but you do not desi representative of the Texas Department of Health.	ignate a private physician, the test results will be provided to you by a
	CONSENT
	HIV-Related Testing. I voluntarily consent to the collection of a sample of urine from me, the testing of that sample, and the disclosure of the test this form about what a test result means.
I understand that I have the right to request and receive as the original.	a copy of this authorization. A photocopy of this form will be as valid
Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian
Address	Date Signed:
Form 1880-TX; Rev. 6-2006	White copy-Home Office Yellow copy-Applicant