INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITITES℠

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 Proposed Insured _____ Date of birth _____

1. Have you lost or gained weight during the past year? ☐ Yes ☐ No
   If Yes, specify: Pounds lost _____ Pounds gained _____
2. Name of personal physician/medical facility who can provide the most complete, up-to-date information about your present health: _____
   a. Address and phone number of personal physician/medical facility: _____
   b. List all currently prescribed medications, dosage, and frequency:

3. Are your parents or any siblings deceased or ever been treated by a member of the medical profession for heart disease, diabetes, cancer, or mental illness? ☐ Yes ☐ No
   If Yes, indicate below:

Parent or Sibling	Current age	Age at death	State of health or cause of death

4. In the past five years, have you ever received counseling or treatment from any physician for, or been advised by a physician to discontinue the use of alcohol or the use of prescribed or non-prescribed drugs? ☐ Yes ☐ No
5. In the past 10 years, have you used amphetamines, barbiturates, cocaine, narcotics, marijuana, or other depressant, excitant, or hallucinatory drugs, unless administered on the advice of a physician? ☐ Yes ☐ No
6. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
7. In the past five years, have you ever been diagnosed as having, been treated by a member of the medical profession for, or tested positive for:
   a. Heart attack; high blood pressure; stroke; TIA, cerebrovascular disease, or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   b. Cancer, tumor, cyst, mass; leukemia; lymph gland; thyroid; anemia; or any other blood abnormalities? ☐ Yes ☐ No
   c. Diabetes or other endocrine disorder; sugar, albumin, or blood in urine; pancreatitis; disorder of kidney, bladder, or prostate? ☐ Yes ☐ No
   d. Asthma; bronchitis; emphysema; pneumonia; tuberculosis; or any other disorder of the lung/respiratory system? ☐ Yes ☐ No
   e. Intestinal bleeding; ulcer; hepatitis; or other disorder of throat, stomach, liver, intestine, or gallbladder? ☐ Yes ☐ No
   f. Any disease or disorder of the reproductive system or breasts? ☐ Yes ☐ No
   g. Brain, mental, or emotional nervous disorder; dementia, Alzheimer's, eye disorder, epilepsy, seizures, paralysis; depression; anxiety; or any other disease or disorder of the nervous system? ☐ Yes ☐ No
   h. Arthritis; loss of limb, or deformity; disorder of bone, joint, muscle, back, or spine; skin disorder; lupus, connective tissue disorder; or any other disorder of the musculoskeletal system? ☐ Yes ☐ No
8. Excluding tests related to Human Immunodeficiency Virus (AIDS virus), during the past 5 years, have you:
   a. Had any surgery or diagnostic test, such as an electrocardiogram, X-ray, MRI, CT scan, biopsy, or blood study? ☐ Yes ☐ No
   b. Been advised to have any diagnostic test, hospitalization, or surgery that has not been completed? ☐ Yes ☐ No
   c. Had treatment as an inpatient or outpatient or are you currently confined in a hospital, institution, clinic, or other medical facility? ☐ Yes ☐ No

Give full details including dates and results for any YES answers to questions 4 through 8 above:

Question #	Name of personal physician or medical facility and Address	Illness Date/Duration	Diagnosis/Medications/Treatments

I hereby state that I am the person named as the applicant. I have read all of the foregoing answers and statements, adopt them as my own, whether written by me or not, and hereby declare that they are complete and true to the best of my knowledge and belief. I hereby agree that all of said answers and statements shall be taken as, and be a part of, my said application and be subject to the agreements therein contained.

Dated at (City and State) _____, this _____ day of _____, 20 _____

Witnessed by _____ Signature of Proposed Insured _____
(Paramedical Examiner)

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

1. MEASUREMENTS
   a) HEIGHT _____ ft. _____ in. b) WEIGHT _____ lbs.
   c) Did you weigh? ..... ☐ YES ☐ NO
   d) Did you measure? ..... ☐ YES ☐ NO

2. BLOOD PRESSURE - If systolic reading is over 140 or diastolic is over 90, take and record three readings.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

3. PULSE (seated)
   Rates per minute at rest _____
   Irregularities per minute at rest _____

4. How long have you known the applicant? _____

Comments: _____

_____

_____

_____

_____

I certify that I have carefully examined the applicant and that, in my opinion, the foregoing statements and answers on this page are true.

Examiner's Signature _____
Examiner's Address _____
This examination was made on: Date _____ City, State & Zip Code _____

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230 16th Street • Rock Island, IL 61201
(309) 788-4561 • (800) 627-4762
contact@royalneighbors.org • www.royalneighbors.org

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 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

White copy-Home Office *Yellow copy-Applicant*