PART II MEDICAL HISTORY

USA Life Insurance Company, Inc. **Toll Free: 866-SUSA-123 (866-787-2123) www.susa.com**

1. a. Proposed Insured (please print) First Name M.I. Last Name	b. Birth Date Month/Day/Year	c. Height ft. in.	d. Weight lbs.

2. a. Print name and address of your personal physician: (If none, check box) ☐ None

Physician Name and Address

First Name M.I. Last Name

Number & Street Address

City State Zip Code

b. Date and reason last consulted personal physician:

Month/Day/Year

Reason:

c. What treatment was given or recommended?

3. Have you within the past 5 years: **(Check the applicable items)**	Yes	No
a. Consulted or been examined or treated by any physician or practitioner?	☐	☐
b. Had any surgery?	☐	☐
c. Been treated for or been diagnosed as having any illness or injury?	☐	☐
d. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
e. Had electrocardiogram, X-ray, or other diagnostic test (except for HIV)?	☐	☐
f. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed (except for HIV)?	☐	☐

4. Have you ever been treated for or been diagnosed as having: **(Check the applicable items)**	Yes	No
a. Disease or disorder of eyes, ears, nose or throat?	☐	☐
b. Dizziness, fainting, convulsions; paralysis or stroke; mental or nervous disease or disorder?	☐	☐
c. Shortness of breath; blood spitting; bronchitis, asthma, emphysema, tuberculosis or other chronic respiratory disease or disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?	☐	☐
e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids or other disease or disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of kidney, bladder, prostate, or reproductive organs?	☐	☐
g. Diabetes; cyst, tumor, or cancer; thyroid or glandular disorder; skin disease or disorder?	☐	☐
h Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Allergies; anemia; other blood or lymph disease or disorder?	☐	☐
k. AIDS (Acquired Immuno-Deficiency Syndrome) or ARC (AIDS Related Complex)?	☐	☐
5. Are you now under observation or taking treatment?	☐	☐
6. Have you ever:		
a. Used barbiturates, amphetamines, hallucinatory drugs, heroin, opiates or other narcotics except as prescribed by a physician?	☐	☐
b. Received counseling or treatment regarding the use of alcohol or drugs?	☐	☐

7. Have you ever had military service or employment deferment, rejection, retirement or discharge because of a physical or mental condition? ☐ Yes ☐ No

8. Have you used tobacco in any form, including, but not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, and snuff?
In the last 12 months ☐ More than 3 years ago ☐ Never ☐

9. Has any parent or sibling:
   a. **died** of cancer or cardiovascular disease prior to age 60? ☐ Yes ☐ No
   b. **been diagnosed** with cancer or cardiovascular disease prior to age 60? ☐ Yes ☐ No

If answered "yes" to a. or b., indicate relationship, age, and specify condition:

10. GIVE DETAILS FOR "YES" ANSWERS. If necessary, attach extra pages. Include:

i. Question Number
ii. Diagnosis & Treatment
iii. Results
iv. Dates & Duration
v. Names & Addresses of all attending physicians & medical facilities

Signed in my presence

Month/Day/Year

X

Signature of medical examiner

The statements herein are true, fully and correctly recorded, and made for the purpose of inducing the Company to issue insurance on my life.

X

Signature of proposed Insured

PART III MEDICAL EXAMINERS REPORT

11. a. Height (in shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	Details of "Yes" answers. *(Identify item)*

b. Did you weigh? ..... ☐ Yes ☐ No Did you measure? ..... ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ..... ☐ Yes ☐ No

If yes, provide details.

12. Blood Pressure (Record ALL Readings) – Report 3 readings if first is 140/90 or higher, or history of hypertension or other cardiovascular disorder.

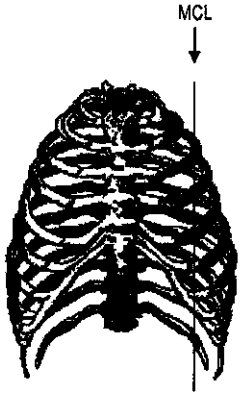
Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

13. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

14. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below – if more than one, describe separately)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:	☐	☐
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex X
Murmur area by
Point of greatest intensity by O
Transmission by



For comments and your impression?

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

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx?	☐	☐
(If vision or hearing is markedly impaired, indicate degree and correction)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
16. (a) Are there any hernias? ..... ☐ Yes ☐ No (b) Any hemorrhoids?	☐	☐
17. Are you aware of any additional medical history? ..... (A confidential report may be sent to the Medical Director)	☐	☐

Examiner's Comments and Observations: _____

I hereby certify that I have made this examination of the proposed insured

On this day of , 20 at AM PM

_____ , M.D.
Medical Examiner