Protector UL

INDIVIDUAL LIFE INSURANCE APPLICATION PART II - MEDICAL EXAMINATION

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033

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1. Proposed Insured Name _____ Birth Date _____ SSN _____

2. Personal Physician or Clinic Name _____ Phone Number _____

3. Personal Physician or Clinic Address _____

City _____ State _____ ZIP _____

4. Date last seen by Physician _____ Reason for Consultation _____

5. Consultation Results _____

6. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:

a. Dizziness, seizures, convulsions, headaches, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression? ☐ Yes ☐ No
b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder? ☐ Yes ☐ No
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder? ☐ Yes ☐ No
e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or any other disorder of the kidney, bladder, breasts, prostate, or reproductive organs? ☐ Yes ☐ No
f. Diabetes, thyroid, or any other endocrine disorder? ☐ Yes ☐ No
g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints or bones? ☐ Yes ☐ No
h. Anemia or any other disorder of the blood? ☐ Yes ☐ No
i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? ☐ Yes ☐ No

7. Have you:

a. Had any operation(s) in the past 5 years? ☐ Yes ☐ No
b. In the past 5 years been advised to have any operation, treatment, or diagnostic tests that have not yet been performed? ☐ Yes ☐ No
c. Had an electrocardiogram, X-ray, or other diagnostic test in the past 5 years (excluding HIV testing)? ☐ Yes ☐ No
d. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? ☐ Yes ☐ No
e. In the past 5 years, been confined for observation, care, or treatment in a hospital or other health care facility? ☐ Yes ☐ No
f. In the past 5 years, consulted any health care provider(s) not already identified, for any reason including routine physical examination? ☐ Yes ☐ No
g. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer? ☐ Yes ☐ No

8. Are you:

a. Presently taking any medication(s), including non-prescription/over-the-counter medication or supplements? ☐ Yes ☐ No
b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbituarates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? ☐ Yes ☐ No

9. Family History			
Relationship	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

10. Explanations *(For any "Yes" answer to questions 6-8 on the previous page, please record information in chart below. If you need additional space, please attach a separate piece of paper to the application.)*

Question	Condition/Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

I have read the statements given in the Individual Life Insurance Application Part II - Medical Examination and affirm that they are complete and true to the best of my knowledge and belief.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Signed at (City, State) _____ Date _____

Proposed Insured Signature *(if age 15 or older)* _____ Date _____

Parent/Guardian Signature _____ Date _____
(if the Proposed Primary Insured is a minor)

Examiner Signature _____ Date _____

MEDICAL EXAMINER'S REPORT *(Provide further clarification in question 12 below.)*

1a. How long have you known the Proposed Insured? _____

b. Are you related to him/her or to the agent? . . . . . ☐ Yes ☐ No

2a. Exact weight _____ b. Exact height _____

c. Weight increase/decrease in last year _____

d. Girth (males only)

Chest at forced inspiration _____ Abdomen _____

3. Blood Pressure: (Use right arm while seated. Two readings are recorded, none disregarded. If systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 minutes of rest.)

	1st	2nd	3rd	4th
Systolic				
Diastolic				

4a. Rate of Pulse _____

b. Peripheral pulses: ☐ Normal ☐ Decreased

c. Is there any irregularity or abnormality of the cardiac rhythm? ☐ Yes ☐ No

Nature of irregularity _____

Number of irregularities per minute _____

Number of irregularities after exercise _____

5a. Is there any abnormality of the quality or intensity of the heart sounds? . . . . . ☐ Yes ☐ No

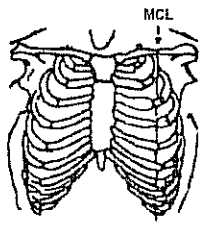
b. Are there any heart murmurs? . . . . . ☐ Yes ☐ No

If "Yes", diagnosis: ☐ Functional ☐ Organic

Type _____

Please indicate:

Timing	Intensity	Quality
☐ Systolic	☐ Faint	☐ Soft
☐ Presystolic	☐ Moderate	☐ Blowing
☐ Diastolic	☐ Loud	☐ Rough



Indicate on diagram point of maximum intensity or murmur with O and direction of transmission with ➔

6. Is the heart enlarged? . . . . . ☐ Yes ☐ No

7. Does the Proposed Insured currently use or has he or she ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches? . . . ☐ Yes ☐ No

If "Yes", type and daily amount _____

Date last used _____

8. Have you found any evidence of past or present disease of:

a. Head or neck? . . . . . ☐ Yes ☐ No

b. Eyes, ears, nose or throat? . . . . . ☐ Yes ☐ No

c. Lymph nodes? . . . . . ☐ Yes ☐ No

d. Brain or nervous system? . . . . . ☐ Yes ☐ No

e. Lungs or chest? . . . . . ☐ Yes ☐ No

f. Abdomen? . . . . . ☐ Yes ☐ No

g. Genito-urinary system? . . . . . ☐ Yes ☐ No

h. Extremities or peripheral vessels? . . . . . ☐ Yes ☐ No

i. Skin? . . . . . ☐ Yes ☐ No

j. Any other part of the body? . . . . . ☐ Yes ☐ No

9a. Is there evidence of dementia? . . . . . ☐ Yes ☐ No

b. Is the Proposed Insured able to walk and to rise from a seated position without aid? . . . . . ☐ Yes ☐ No

10. If your examination revealed any condition requiring further investigation or immediate treatment, have you advised the Proposed Insured? ☐ Yes ☐ No

Explain any "Yes" answers for questions 1 -10 in #12 below.

11a. Was the EKG completed? (if required). . . . . ☐ Yes ☐ No

b. Have the blood and urine specimens been sent? . . . ☐ Yes ☐ No

c. Lab ticket number _____

d. Name of Lab _____

For females only.

e. Was the Proposed Insured menstruating at the time the urine specimen was voided? . . . . . ☐ Yes ☐ No

f. Is the Proposed Insured pregnant? . . . . . ☐ Yes ☐ No

12. Remarks and Explanations

To the Medical Examiner: Any erasures or alterations in this report should be initialed by you.

Examination was made at: ☐ Proposed Insured's Residence ☐ Proposed Insured's Business ☐ Examiner's Office ☐ Other _____

Examiner's Name *(please print)* _____

➔ Examiner's Signature _____ Date _____

Examiner's Address _____

Phone Number _____ SSN/TIN _____ ☐ Board Certified ☐ Board Eligible