PART 2, STATEMENT TO MEDICAL EXAMINER

Continuing Application to Southern Farm Bureau Life Insurance Company, Jackson, Miss.

Social Security No. _____ Policy/Application No. _____

1. Full Name (Print)	2. Male or Female	3. Birthdate Mo. Day Yr.	4. Age
5. Address Street or R.F.D. No. City State Zip Code	M ☐ F ☐		

Answer each of the following questions "Yes" or "No". For each question answered "Yes", give complete details in space provided. ANSWER EVERY QUESTION.

To the best of your knowledge and belief, have (are) you:	Yes	No
6. ever		
(a) been declined, postponed, rated, or charged an extra premium for life or health insurance?	☐	☐
(b) attempted suicide?	☐	☐
(c) been rejected or deferred from military service or been given a medical discharge?	☐	☐
(d) been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
7. in the past 5 years		
(a) been in, or advised to go to, a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?	☐	☐
(b) had x-ray, electrocardiogram, blood study, or other diagnostic test?	☐	☐
(c) received or claimed benefits for any injury or sickness?	☐	☐
8. ever been diagnosed or treated by a member of the medical profession for		
(a) dizziness, fainting spells, epilepsy, mental or nervous disorder (including but not limited to depression), severe headaches, or any disease or disorder of the brain or nervous system?	☐	☐
(b) asthma, emphysema, hay fever, chronic cough, spitting of blood, tuberculosis, sleep apnea, or any disease or disorder of the lungs or respiratory system?	☐	☐
(c) high blood pressure, chest pain, shortness of breath, heart murmur, or any disease or disorder of the heart or circulatory system?	☐	☐
(d) any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder?	☐	☐
(e) nephritis, kidney stone, any disease or disorder of the kidneys or bladder, or any tumor or disease of the prostate, testes, breasts, uterus, ovaries, or complications of pregnancy?	☐	☐
(f) gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?	☐	☐
(g) rheumatic fever, diabetes, or sugar, albumin, or blood in the urine?	☐	☐
(h) cancer, or tumor or ulcer of any kind, or venereal disease?	☐	☐
(i) varicose veins, varicose ulcers or phlebitis, or a hernia of any kind?	☐	☐
(j) any disease or disorder of the eyes, ears nose or throat?	☐	☐
(k) anemia, goiter, or any disease or disorder of the blood or lymph glands?	☐	☐
9. in the past 5 years		
(a) consulted or been treated or examined by any physician or practitioner not named above or for any other causes?	☐	☐
(b) had regular physical examinations?	☐	☐
(c) used alcoholic beverages to excess or intoxication of barbiturates, sedatives, or tranquilizers habitually, or been arrested for driving while intoxicated?	☐	☐
(d) used heroin, morphine, cocaine, L.S.D., marijuana, or any amphetamine, or other narcotic or addictive drug?	☐	☐
10. in the past 2 years gained or lost more than 10 pounds of weight? (if "Yes," state which and give the reason)	☐	☐
11. now		
(a) have you been diagnosed or treated by, or consulted with, a physician or other health advisor for any disease or disorder not disclosed above?	☐	☐
(b) receiving treatment or taking medication of any kind?	☐	☐
(c) pregnant (if "Yes", indicate month of pregnancy)	☐	☐
(d) engaged in a regular program of exercise	☐	☐
12. Have any of your parents, brothers, or sisters ever had heart disease, cancer, diabetes, mental illness, or attempted or committed suicide? (If yes, give details)	☐	☐
13. During the last 2 years have you missed work or school because of any illness or injury? If "yes", the number of days and reasons	☐	☐
14. Smoked cigarettes or used tobacco in any form in the past 24 months?	☐	☐

Give complete details for every "Yes" answer to the questions 6-14. Include question number, details, dates, name and address of attending physicians, and hospitals:

I hereby represent that my answers to the foregoing questions are complete and true to the best of my knowledge and belief and I expressly agree that this Part 2 shall form a part of my application for life insurance.

I hereby authorize any licensed physician, medical practitioner, hospital, veterans hospital, clinic or other medical or medically related facility that has any records or knowledge of me or my health to give Southern Farm Bureau Life Insurance Company, or its reinsurers, any such information.

Dated at _____ this _____ day of _____, Yr. _____

Witness to Signature _____ M.D._____ Proposed Insured
(Signature in Full)

PART 3, REPORT OF MEDICAL EXAMINER

1. How long have you known Proposed Insured?	
2. Are you related to the Proposed Insured or the agent?	
3. In your opinion, is the Proposed Insured a good insurance risk? If not, please comment in No. 19.	
4. a. Height	ft. in.
b. Weight without coat	lbs.
c. Chest: Forced expiration	in.
Forced inspiration	in.
d. Circumference of abdomen	in.
e. Did you: Weigh Proposed Insured? Measure Proposed Insured?	
5. Blood Pressure: Systolic	
Diastolic { At 4th phase	
At disappearance of sound	
6. Pulse: Rate seated. (If intermittent or irregular complete heart chart.)	
7. Heart: (If any abnormality complete heart chart) { Any murmurs?	
Any enlargement?	

8. COMPLETE HEART CHART…IF:

a. Any abnormality of the heart is found.
b. Systolic blood pressure is over 140 or under 100.
c. Diastolic blood pressure is over 90.
d. Pulse pressure is over 60 or under 30.
e. Pulse is irregular, or rate is over 90 or under 60.
f. There is history of rheumatic fever.
g. Heart has ever been criticised.
h. There are symptoms of toxic goiter.

Exercise Test: Require the Proposed Insured to take fifty vigorous hops, 10 bending exercises, or enough exercise to raise the pulse rate to 100 or more

		Before Exercise	Immediately After Exercise	Three Min. Later
a. Pulse	Rate			
	Number of irregularities per minute			
b. Blood Pressure	Systolic			
	Diastolic (5th Phase)			
c. Murmur				

d. Are there any evidences of failing compensation such as Dyspnea, Cyanosis or Edema?

e. Is the point of maximal impulse abnormal in location?

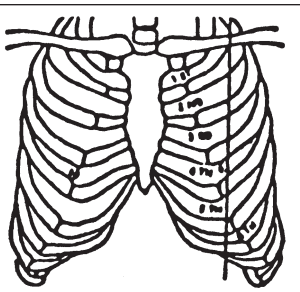
f. Hypertrophy present? _____ Slight ____ Moderate ____ Marked ____

g. Murmur is:
☐ Constant ☐ Transmitted ☐ Systolic ☐ Presystolic ☐ Diastolic ☐ Apical ☐ Aortic ☐ Other ☐ Soft (Gr. 1-2) ☐ Mod. (Gr. 3-4) ☐ Loud (Gr. 5-6)
☐ Inconstant ☐ Localized

After exercise: ☐ Unchanged ☐ Increased ☐ Decreased ☐ Absent

Does murmur impress you as organic? _____ As functional? _____

Show Location of:
Apex by _____X
Area of murmur by _____☐
Point of greatest intensity by _____○
Transmission by _____➡



Diagnosis?
Your Impression?

9. a. Are eye grounds abnormal? b. Is vision abnormal?	
10. Any hearing or ear disorder?	
11. Any pathology of skin, breasts, Lymph nodes or throat?	
12. Any deformity or defect?	
13. Any goiter? If yes, state size and kind.	
14. Lungs: Is there any evidence of past or present disease? Give details.	
15. Abdomen: a. Any scars?	
b. Any tenderness or masses?	
c. Any Hernia? Character and extent?	
d. Any enlargement of liver or spleen?	
16. Has the applicant ever had syphilis or other venereal disease?	
17. Brain or nervous system: a. Are the pupils unequal?	
b. Are the pupils fixed?	
c. Are knee jerks abnormal?	

18. Comments or details regarding health, habits or character.

19. Examination was made:
At Proposed Insured's place of business ☐ at _____ A.M.
At Proposed Insured's residence ☐
At Examiner's office ☐ _____ P.M.

on _____
Month Day Year

_____ M.D.
Signature of Medical Examiner

_____
Address of Medical Examiner

_____
Print Name If Signature Illegible

STATE YOUR FEE HERE $_____

PLEASE PRINT THE NAME OF AGENT REQUESTING EXAM:_____

AGENT'S CODE:_____