

**Paramed Exam
Form**

*American United Life
Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 369
Indianapolis, IN 46206-0368
(317) 285-1877*

*Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United
Mutual Insurance Holding Company
a ONEAMERICA® company
101 North 10th Street
Fargo, ND 58102
(701) 297-5700*

*The State Life
Insurance Company
a ONEAMERICA® company
P.O. Box 406
Indianapolis, IN 46206
(317) 285-2300*



ANSWERS MADE TO THE MEDICAL EXAMINER

Please print or type. Use black ink. Do not use dashes or ditto marks.

<i>Full Name of Proposed Insured</i> _____	<i>Date of Birth</i> _____	<i>Social Security Number</i> _____
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Name and Address of Personal Physician (If none, state "None") _____

Date, reason and results of Proposed Insured's last doctor visit or consultation. _____

<p>1. Is the Proposed Insured now under observation, receiving treatment or taking medication prescribed by a member of the medical profession? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. In the past 10 years, has the Proposed Insured ever been diagnosed as having, been treated for or ever had (Circle Applicable Items):</p> <ul style="list-style-type: none">a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> Nob. Cancer, tumors, Kaposi's sarcoma, disorder of the skin, swelling of the lymph glands, fever of unknown origin, night sweats, lupus or collagen disorder, arthritis or any bone or muscle disease? <input type="checkbox"/> Yes <input type="checkbox"/> Noc. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, Alzheimer's, senile dementia, nervous or mental disorder including anxiety, depression, attempted suicide or a suicidal gesture? <input type="checkbox"/> Yes <input type="checkbox"/> Nod. Shortness of breath, persistent hoarseness or cough, blood spitting, pneumocystis carinii pneumonia, bronchitis, asthma, emphysema, tuberculosis, allergies, sleep apnea, or other chronic respiratory system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> Noe. Diabetes, thyroid or other endocrine disorder, elevated blood sugar, albumin, blood, sugar or pus in the urine, stone or other disease of kidney, bladder, prostate or reproductive organs? <input type="checkbox"/> Yes <input type="checkbox"/> Nof. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of the stomach, intestine, gallbladder or spleen? <input type="checkbox"/> Yes <input type="checkbox"/> Nog. Hepatitis, cirrhosis or other disorder of the liver or pancreas? <input type="checkbox"/> Yes <input type="checkbox"/> Noh. Anemia, bleeding tendency or other disorder of the blood? <input type="checkbox"/> Yes <input type="checkbox"/> Noi. Disorder of eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> Noj. Deformity, lameness or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> Nok. Any indication, diagnosis or treatment of alcohol or drug dependency, abuse or reaction? <input type="checkbox"/> Yes <input type="checkbox"/> Nol. Is the Proposed Insured pregnant? If yes, due date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <p>3. Within the past 5 years, has the Proposed Insured (Circle Applicable Items):</p> <ul style="list-style-type: none">a. Had a checkup, consultation, illness, injury or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> Nob. Had a diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study? <input type="checkbox"/> Yes <input type="checkbox"/> Noc. Been a patient in a hospital, clinic, sanitarium, extended care facility, nursing home, hospice or other medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> Nod. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed or where results are still pending or have a doctor's appointment scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> Noe. Had any condition resulting in over 10 consecutive days of time lost from work or required assistance for a period longer than one week pertaining to activities of daily living; such as bathing, dressing, continence, eating, toileting and transferring? <input type="checkbox"/> Yes <input type="checkbox"/> Nof. Requested or received home nursing or home healthcare, a pension, benefits or payment because of injury, sickness or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>4. Record details of "Yes" answers. IDENTIFY QUESTION NUMBER. Include all dates, diagnoses, names and addresses of all attending physicians and medical facilities. (Enter additional details on page 2.)</p>	
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Details of "Yes" answers continued:

5. Family History:

	Age if still Living	Age at Death	State of Health/ Cause of Death	Cancer (Any type)	Heart disease, stroke or circulatory disorder	Diabetes
Mother	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Siblings	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Nicotine and/or Tobacco Use:

a. ☐ Never ☐ Present ☐ Former

b. Type of nicotine or tobacco used: _____

c. When did the Proposed Insured quit using all forms of nicotine or tobacco? (month/year) _____

7. Immune Deficiency – Has the proposed insured:

a. ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia; ☐ Yes ☐ No

b. 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

I have read the statements and answers made above. They are, to the best of my knowledge and belief, true, complete and correctly recorded. This supplement will become a part of my application for insurance and will be a part of the basis of any insurance issued.

Signed at _____, on _____
City State Date

Signature of Proposed Insured

Witness _____

Signature of Representative

Medical Examiner's Report (Paramedical Technician: Complete sections 1, 2 (a,b,c), 4, 5, 6, 7 and 8.)
(Physicians: Complete all sections.)

INSTRUCTIONS TO THE MEDICAL EXAMINER: Answers must be in your handwriting. Any erasures or alterations in this report should be initialed by you. Record details of "Yes" answers in #8. If you prefer to do so, you may send this report, or any information which you prefer not to include in this report, directly to the Medical Director of the Company, P.O. Box 6003, Indianapolis, IN 46206.

Proposed Insured's Name: _____

<p>1. a. Height ____ft. ____in. Weight ____lbs. <i>Males only:</i> Chest (full inspiration) ____in. Chest (forced expiration) ____in. Abdomen (at umbilicus) ____in. b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Any change in weight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, loss ____lbs. / gain ____lbs d. Reason for any change? _____</p>	<p>3. Do you find any evidence of past or present disease or abnormality of <i>(Circle Applicable Items)</i>:</p> <p>a. Head and/or neck? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Lungs or chest? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Abdomen? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Genito-urinary system? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Extremities or peripheral vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Skin? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Any other parts of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
<p>2. Cardiovascular Examination:</p> <p>a. Blood Pressure (sitting) – Please take 3 readings</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">1st</th> <th style="text-align: center;">2nd</th> <th style="text-align: center;">3rd</th> </tr> </thead> <tbody> <tr> <td>Systolic</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Diastolic</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>b. Pulse Rate _____</p> <p>c. Irregularities _____</p> <p>d. Is the heart enlarged? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Is there a murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TIMING: <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic</p> <p>INTENSITY: <input type="checkbox"/> Systolic <input type="checkbox"/> Presystolic <input type="checkbox"/> Diastolic</p> <p>f. In your opinion, would you describe the murmur as: <input type="checkbox"/> Functional <input type="checkbox"/> Organic</p>		1st	2nd	3rd	Systolic	_____	_____	_____	Diastolic	_____	_____	_____	<p>4. Are you aware of any additional medical history or obvious abnormalities concerning the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you and the Proposed Insured related or are you and the Proposed Insured business or professional associates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. How did you identify the Proposed Insured? (if related, explain in #8) <input type="checkbox"/> Well known to you <input type="checkbox"/> Photo ID <input type="checkbox"/> Related</p> <p>7. Examination was done: at <input type="checkbox"/> Office <input type="checkbox"/> Residence of <input type="checkbox"/> Examiner <input type="checkbox"/> Proposed Insured at _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p>
	1st	2nd	3rd										
Systolic	_____	_____	_____										
Diastolic	_____	_____	_____										
<p>8. DETAILS of "Yes" answers. (If you are the attending physician, please attach a copy of the patient's records.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>													

I certify that I have personally asked all questions and accurately recorded the answers. I personally performed the physical measurements and recorded my observations.

Signed at: _____ Date _____
City State

Signature of Examiner _____ Printed Name _____

Name of Paramedical Company: _____ Phone No.: _____

Address _____ City _____ State _____ Zip Code _____

If the Examiner is an M.D., name of Specialty: _____
☐ Board Certified ☐ Board Eligible

**Informed
Consent**

*American United Life
Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442*

*Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United
Mutual Insurance Holding Company
a ONEAMERICA® company
101 North 10th Street
Fargo, ND 58102
(701) 297-5700*

*The State Life
Insurance Company
a ONEAMERICA® company
P.O. Box 6062
Indianapolis, IN 46206*



TEXAS NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from 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 antibodies 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 persons.

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 the meaning.

Name of Physician for reporting possible positive test result: _____

Address: _____

If 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.

Please Print Name of Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed