

## Application Part 1

## STONEBRIDGE LIFE INSURANCE COMPANY

Home Office: Rutland, VT • Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

## MEDICAL QUESTIONS

Full name of person proposed for insurance:

Date of Birth (Month/Day/Year):

Name, address and telephone number of your personal physician. (If none check box) ☐ None

Date and reason last consulted?

What treatment was given or medication prescribed?

**MEDICAL QUESTIONS** - Each question must be individually asked and answered.

To the best of your knowledge, has any Proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

	Yes	No		Yes	No
1) Illness, injury or disease of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	11) Any illness or disease of the male or female reproductive organs, sexually transmitted disease, prostate problems, irregular menstruation or abnormal pap test?	<input type="checkbox"/>	<input type="checkbox"/>
2) Epilepsy, seizures, chronic headaches, head injury, paralysis, or other disorder of the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	12) An examination, treatment or consultation with a doctor or health care provider other than above?	<input type="checkbox"/>	<input type="checkbox"/>
3) Anxiety, depression, affective disorder, eating disorder, psychotic disorder, or other psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>	13) Had or been advised to have a check-up, consultation, lab test, EKG, x-ray, or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
4) Asthma, emphysema, tuberculosis, shortness of breath, persistent hoarseness or cough, or other respiratory illness or disease?	<input type="checkbox"/>	<input type="checkbox"/>	14) Received or been advised to have treatment for drug usage, whether legal or illegal, alcoholism or been a member of AA?	<input type="checkbox"/>	<input type="checkbox"/>
5) High blood pressure, heart attack, stroke, heart murmur, palpitation, arrhythmia, chest pain, rheumatic fever, or other illness or disease of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	15) Are you currently under the observation of a physician or taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
6) Ulcer, colitis, Crohn's disease, diverticulitis, hepatitis, intestinal bleeding, or illness or disease of the gallbladder, stomach, intestines, or liver?	<input type="checkbox"/>	<input type="checkbox"/>	16) Family History: Is there a history of cardiovascular disease or cancer in parent/siblings prior to age 60?	<input type="checkbox"/>	<input type="checkbox"/>
7) Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system?	<input type="checkbox"/>	<input type="checkbox"/>	17) Do you participate in a regular, supervised exercise program or other organized sport?	<input type="checkbox"/>	<input type="checkbox"/>
8) Diabetes, thyroid disorder, cholesterol elevation, anemia, or other illness or disease of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	18) Do you know of any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure, Diabetes, or committed suicide? (Please show age at onset and/or date of death).	<input type="checkbox"/>	<input type="checkbox"/>
9) Arthritis, gout, lupus, illness, injury or disease of the back, spine or joints, or other illness, injury or disease of the muscles, bones or skin?	<input type="checkbox"/>	<input type="checkbox"/>	19) Have you had any weight change in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
10) Cysts, tumor, skin cancer or any other cancer or malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	20) Have you or any Proposed Insured EVER been diagnosed as having or been told by a medical doctor that you have AIDS, HIV, or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>

## FAMILY HISTORY

	Age if Living?	Status of Health	Age of Death?	Cause of Death?
Father				
Mother				

## Give details regarding "yes" answers number 1-20 (Please print)

Question No.	Disease, symptom, injury, etc.	Dates	Duration	No. of Attacks	Name and Address of Attending Physicians and Hospitals

I certify and represent that I have read and understand all the statements and answers herein and in Part 1 of my application; that they are true and correct, and are correctly recorded whether written in my own hand or not. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. I agree that this and any other application, any amendments or endorsements and any policy or policies issued based on this and any other application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgement and ratification of any corrections made in the application; except, that no change in amount of insurance, age at issue, classification, kinds of insurance or benefits will be made unless agreed in writing by the applicant and an officer of the Company.

I further acknowledge that the information contained in Parts 1 and 2 of this form is being obtained on behalf of Stonebridge Life Insurance Company and that such information will be released to the Company, its agents, employees, representatives and reinsurers.

Date \_\_\_\_\_

Signature of Proposed Insured \_\_\_\_\_

Examiner \_\_\_\_\_

6600-R1006 TX

Signature of Parent if insured is a minor \_\_\_\_\_

# STONEBRIDGE LIFE INSURANCE COMPANY

Home Office: Rutland, VT • Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

## Part 2 — MEDICAL EXAMINER'S REPORT

21. Your patient? ☐ Yes ☐ No If so, how long?

22. Height (in shoes) Weight (clothed)  
Ft. In. Lbs.

### Males Only

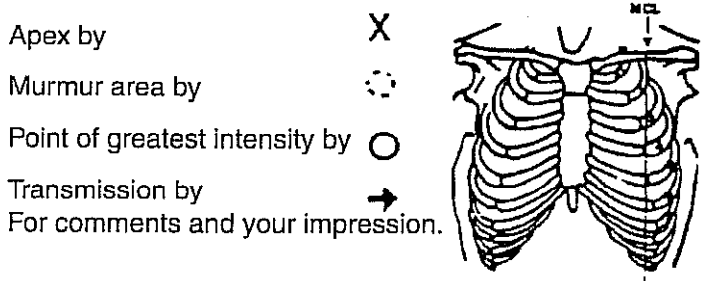
Chest (full inspiration) In.	Chest (forced expiration) In.	Abdomen (at umbilicus) In.
------------------------------------	-------------------------------------	----------------------------------

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

23. Blood Pressure (Record all readings.) If initial blood pressure is elevated (140/90 or over), please give repeat readings.

	Initial Reading	After Exercise	3 Minutes Later
Systolic			
Diastolic 5th phase			
24. Pulse	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

25. Heart			Murmur	No. 1	No. 2
Is there any:	Yes	No	Location		
Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constant	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Murmur(s)*	<input type="checkbox"/>	<input type="checkbox"/>	Localized	<input type="checkbox"/>	<input type="checkbox"/>
*Describe below. If more than one, describe separately.)			Systolic	<input type="checkbox"/>	<input type="checkbox"/>
			Presystolic	<input type="checkbox"/>	<input type="checkbox"/>
			Diastolic	<input type="checkbox"/>	<input type="checkbox"/>
			Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>
			Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>
			Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>
			After exercise:		
Indicate:			Increased	<input type="checkbox"/>	<input type="checkbox"/>
			Absent	<input type="checkbox"/>	<input type="checkbox"/>
			Unchanged	<input type="checkbox"/>	<input type="checkbox"/>
			Decreased	<input type="checkbox"/>	<input type="checkbox"/>



26. 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 markedly impaired, indicate degree and correction.
- b. Skin (include 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 (include prostate)? . ☐ ☐
- g. Endocrine system (include thyroid and breasts)? ..... ☐ ☐
- h. Musculoskeletal system (include spine, joints, amputations, deformities)? ..... ☐ ☐
27. a. Are there any hernias? ☐ ☐  
b. Any hemorrhoids? ☐ ☐

(Your confidential report may be sent to the Medical Director)

28. Are you aware of additional medical history?

29. Specific Gravity	Albumin	Sugar

Please complete the Dipstix. Please send a portion of the specimen to Home Office Reference Laboratory, P.O. Box 2035, Shawnee Mission, Kansas 66201.

Details of "Yes" answers. (Identify item number.)

Examination made at the request of \_\_\_\_\_, Agent.

I certify that I have made this examination of \_\_\_\_\_

at \_\_\_\_\_ on \_\_\_\_\_ at A.M./P.M.  
(Place of Examination) (City) (State)

and that the foregoing questions have been asked and the answers of the Applicant recorded as stated.

Signature \_\_\_\_\_ M.D., Medical Examiner

MAIL EXAMINATION DIRECTLY TO: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

- ☐ Life Investors Insurance Company of America
- ☐ Monumental Life Insurance Company
- ☐ Stonebridge Life Insurance Company
- ☐ Transamerica Life Insurance Company
- ☐ Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

**Notice and Consent for  
HIV-Related Testing  
TEXAS**

To evaluate your insurability, the insurer named above ("the Insurer") 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 results 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 positive test result

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone

**Notice and Consent for  
HIV-Related Testing  
TEXAS**

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 withdrawal 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.

\_\_\_\_\_  
Proposed Insured (*Please Print*)

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Street

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Date Birth