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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
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INDIVIDUAL LIFE INSURANCE APPLICATION
PART II – LUC-204

1. PROPOSED INSURED INFORMATION

(a) First Name	(b) Middle Initial	(c) Last Name
(d) Social Security #/Tax ID	(e) Date of Birth	(f) Gender ☐ Male ☐ Female

(g) Name and Address of your personal physician:

Doctor Name _____ Date Last Seen _____

Address _____ Phone # _____
Street/PO Box City State Zip

Date & reason last consulted _____

What treatment was given and/or medication prescribed _____

_____

2. FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
(a) Father			
(b) Mother			
(c) Siblings: #Living _____ #Deceased _____			

	Yes	No
(d) Has any family member listed above been diagnosed with, or treated for, cancer, diabetes or coronary artery disease by a member of the medical profession? If "Yes," identify family member, disorder and age of onset in the **DETAILS** section. If there is a history of cancer, indicate the type of cancer.	☐	☐

3. MEDICAL QUESTIONS

Give complete detail for all yes answers in the **DETAILS** section. Please identify the question number and include diagnosis, dates, duration, treatments and medications prescribed and names/addresses for all physicians and hospitals. If you need additional room please attach on a separate piece of paper.

(a) Within the past 10 years, have you or been treated, or been advised to be treated, by a member of the medical profession for:	Yes	No
i) High blood pressure, irregular heartbeat, chest pain, heart murmur, heart attack, congestive heart failure, or any other disease or disorder of the heart or arteries?	☐	☐
ii) Diabetes, elevated blood sugar or glucose intolerance, thyroid, or other endocrine or glandular disorder?	☐	☐
iii) Seizures, dizziness, fainting, epilepsy, transient ischemic attack, stroke, paralysis, or other neurologic or brain disorder?	☐	☐
iv) Cancer, lymphoma, leukemia, melanoma, cyst or tumor of any kind, malignant or benign?	☐	☐
v) Anemia, bleeding or clotting disorder, or any other blood disorder?	☐	☐
vi) Asthma, shortness of breath, chronic obstructive pulmonary disease, emphysema, tuberculosis, sarcoidosis, or any other disorder of the respiratory system?	☐	☐
vii) Nervous, mental or emotional disorder, or received counseling for depression, anxiety, stress or any other emotional disorder?	☐	☐
viii) Memory loss, dementia, or Alzheimer's disease?	☐	☐
ix) Disease or disorder of the prostate, testicles, breasts, cervix, uterus, kidney or urinary bladder?	☐	☐

x) Muscular dystrophy, multiple sclerosis (MS), Parkinson's disease, tremors, or Lou Gehrig's disease (ALS)?	☐	☐
xi) Ulcers, colitis, ulcerative colitis, Crohn's disease, hepatitis, or other disease of the liver, stomach, esophagus, intestines, gallbladder, or pancreas?	☐	☐
xii) Arthritis, gout, or any bone, joint, or muscle disorder?	☐	☐
xiii) Any other physical or mental disorder, not listed above?	☐	☐
(b) Within the past 5 years, have you had:		
i) Any surgery or admission to a health care facility for treatment or observation for any illness, disease, or accident?	☐	☐
ii) Any additional testing such as EKG's, laboratory testing (excluding testing for the AIDS virus) or x-rays whether as an inpatient or outpatient?	☐	☐
iii) Any diagnosis or treatment by a member of the medical profession for any physical disability or impairment ?	☐	☐
(c) Within the past 5 years, have you been treated or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
(d) Within the past 10 years, have you:		
i) Used or tested positive for marijuana, cocaine or other non-prescribed stimulant, narcotic or depressant?	☐	☐
ii) Been advised to limit or discontinue the use of alcohol or drugs, or been treated for drug or alcohol abuse?	☐	☐
(e) Within the last 24 months, have you:		
i) Received a recommendation from a medical professional for any consultation, testing (excluding testing for the AIDS virus), investigation or surgery that has not yet been completed?	☐	☐
ii) Consulted, or been examined or treated by any physician, chiropractor, psychologist or other health care practitioner or by any hospital, clinic, or other health care facility not already disclosed on this application? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results.)	☐	☐
(f) Have you ever used any form of tobacco or nicotine based products? If yes, mark all that apply and complete the details below.	☐	☐

Type	Frequency	MO/YR Last Used	Type	Frequency	MO/YR Last Used
☐ Cigarettes			☐ Nicotine Patches		
☐ Cigars			☐ Nicotine Gum		
☐ Pipes			☐ Snuff		
☐ Chewing Tobacco			☐ Other (list):		

(g) Do you consume alcoholic beverages? If yes, please include type of beverage, frequency and quantity in the DETAILS section.	☐	☐
(h) List all prescribed medications, over the counter medications, and herbal supplements you have taken within the past 60 days and the dosage of each in the **DETAILS section**.		

DETAILS: For any additional details and "yes" answers to the questions in section 2 and 3, please provide details here:

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief and shall form a part of any policy issued. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed this_____ , at _____ , State of _____
Date City State

_____ _____
Signature of Proposed Insured Signature of Examiner

MEDICAL EXAMINER'S REPORT (not part of the application)

1. a.	Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

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

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

2. Blood pressure (If initial blood pressure elevated, retake later in exam.)

	1	2	3
Systolic			
Diastolic 5th phase			

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

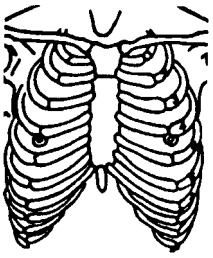
4. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below — if more than one, describe separately)

	Murmur(s) M No. 1	M No. 2
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐



Carefully locate apex by **X**

Indicate entire area within which murmur is heard by ◌

Indicate point of greatest intensity by ○

Indicate direction of transmission by →

Describe all murmurs or abnormal heart sounds. Include intensity, location, area of transmission and pertinent effects of exercise and body position. We want your diagnosis!

5. 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?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Endocrine system (include thyroid and breasts)?	☐	☐
(g) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
(h) Retinopathy (indicate K-W)?	☐	☐
(i) Peripheral pulses? (decreased bruits)?	☐	☐
6. Are there any hernias?	☐	☐
7. Are you aware of anything about the health habits, environment or mode of life of proposed insured which might be unfavorable? (If "yes," give details)	☐	☐
8. Are you unrelated to both proposed insured and agent?	☐	☐

We rely on your clinical thoroughness to help us classify the risk from an insurance point of view. Please make sure all questions are answered and record detail of "yes" and pertinent "no" answers below.

Dip Stick Urinalysis

Sugar?	Albumin?

Have you mailed blood and urine samples to our lab? ☐ Yes ☐ No

Name of Agent

I certify that I have carefully examined _____, whose signature is affixed to the foregoing declarations this _____ day of _____, _____, at _____ o'clock ☐ A.M. ☐ P.M.

Examined at _____ _____ _____ _____
(Town) (County) (State) (Medical Examiner)

_____
(P.O. Address of Medical Examiner)