**TIAA-CREF LIFE INSURANCE COMPANY**
New Business Administration Office: P.O. Box 1291
8500 Andrew Carnegie Boulevard, Charlotte, NC 28262-1291
Home Office: 730 Third Avenue, New York, NY 10017-3206

# LEVEL TERM LIFE INSURANCE APPLICATION – PART II
# MEDICAL REPORT



Please Print in Black or Blue Ink

## INSTRUCTIONS TO EXAMINER

This examination is the property of TIAA-CREF Life Insurance Company and must not be destroyed or suppressed. Please weigh the applicant and answer all questions below. If the answer is "Yes" to any of the questions listed below, provide full details in the "Remarks" section.

## Section A: Proposed Insured

| | | | |
|---|---|---|---|
| Full Legal Name (Title, First, Middle, Last, Suffix) | | | |
| Residential Address | | | Apt. No. |
| City | | State | Zip Code |
| Gender ☐ M ☐ F | Date of Birth | Social Security # | |

## Section B: Medical History

1. PRIMARY CARE PHYSICIAN

| | | | |
|---|---|---|---|
| Name | | Telephone No. | |
| Address | | | |
| City | | State | Zip Code |
| a. Date of last consult with this physician? | m m d d y y y y | | |
| b. Reason for last consult with this physician? | | | |
| c. Test(s) performed and treatment received? | | | |

2. IN THE PAST 10 YEARS, HAS A LICENSED MEMBER OF THE MEDICAL PROFESSION PROVIDED YOU WITH ANY TREATMENT, MEDICAL ADVICE, CONSULTATION OR FOLLOW-UP FOR, OR DIAGNOSED YOU WITH:

| | | |
|---|---|---|
| a. High blood pressure, elevated cholesterol, chest pain, angina, heart attack, heart disease, heart murmur, palpitations, stroke, peripheral vascular disease, cerebrovascular disease, or any other disorder of the heart or circulatory system? | ☐ Yes | ☐ No |
| b. Diabetes, glucose intolerance, thyroid or pituitary disorder or any other endocrine or glandular disorder? | ☐ Yes | ☐ No |
| c. Tumors, malignant or benign, cancer, melanoma or any other disease of the skin, lymphoma, enlarged lymph nodes, leukemia or any other malignant disorder? | ☐ Yes | ☐ No |
| d. Asthma, shortness of breath, COPD, emphysema, pneumonia, bronchitis, tuberculosis, sleep apnea, or any other disorder of the respiratory system? | ☐ Yes | ☐ No |
| e. Depression, anxiety, panic attacks, ADD/ADHD, emotional disorder, or any other psychiatric disorder or disturbance? | ☐ Yes | ☐ No |
| f. Seisure disorder, fainting, dizziness, multiple sclerosis, paralysis, or any other neurological disorder of the brain or nervous system? | ☐ Yes | ☐ No |
| g. Hepatitis, cirrhosis, or any other liver disorder? | ☐ Yes | ☐ No |
| h. Ulcerative colitis, Crohn's disease, gastrointestinal bleeding, gastric or peptic ulcer, acid reflux disease, Barrett's esophagus disease, or disorder of the stomach, pancreas, gall bladder, or any other intestinal disorder? | ☐ Yes | ☐ No |

## Section B: Medical History (Continued)

| | | |
|---|---|---|
| 2. IN THE PAST 10 YEARS, HAS A LICENSED MEMBER OF THE MEDICAL PROFESSION PROVIDED YOU WITH ANY TREATMENT, MEDICAL ADVICE, CONSULTATION OR FOLLOW-UP FOR, OR DIAGNOSED YOU WITH: | | |
| i. Albumin, protein, blood or sugar in the urine or any disorder of the kidney, bladder, breasts, ovaries, prostate or other reproductive organs? | ☐ Yes | ☐ No |
| j. Any sexually transmitted diseases (except HIV)? | ☐ Yes | ☐ No |
| k. Gout, arthritis, connective tissue disease, immune system disorder (except for HIV) or any other disease or disorder of the joints, muscles, nerves or bones? | ☐ Yes | ☐ No |
| l. Anemia, clotting or platelet disorder, chronic infections, or any other disease or disorder of the blood? | ☐ Yes | ☐ No |
| m. Any disorder of the eyes, ears, nose, or throat? | ☐ Yes | ☐ No |
| 3. Are you currently pregnant? | ☐ Yes | ☐ No |
| If Yes, what is the expected date of delivery? m m d d y y y y | | |
| 4. Has your weight changed by more than 10 lbs during the past 12 months? | ☐ Yes | ☐ No |
| If Yes, please provide reason for the weight change; if you gained or lost weight; and how much. lbs. | ☐ Gain | ☐ Loss |
| 5. Have you been diagnosed by a licensed member of the medical profession as having AIDS (Acquired Immunodefiency Syndrome) or HIV (Human Immunodeficiency Virus)? If Yes, please provide details. | ☐ Yes | ☐ No |
| 6. Have you ever been advised by a licensed medical professional to reduce or discontinue the use of alcohol or drugs? | ☐ Yes | ☐ No |
| 7. Other than as noted above, have you ever been counseled or treated because of alcohol, controlled substance or drug use? | ☐ Yes | ☐ No |
| 8. Have you ever used narcotics, amphetamines, barbiturates, heroin, cocaine, marijuana, or other habit-forming drugs, except as prescribed by a licensed medical professional? | ☐ Yes | ☐ No |
| 9. OTHER THAN AS PREVIOUSLY DESCRIBED, IN THE PAST 5 YEARS HAVE YOU: | | |
| a. Consulted with a licenced member of the medical profession, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed (except HIV)? | ☐ Yes | ☐ No |
| b. Been an inpatient or outpatient in a hospital, clinic, medical or mental health facility? | ☐ Yes | ☐ No |
| c. Had any electrocardiograms, x-rays, blood studies, scans, or other diagnostic tests (except HIV)? | ☐ Yes | ☐ No |
| 10. Are you presently taking any medication(s), including nonprescription/over-the-counter medication or supplements? If Yes, list all medications and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over-the-counter drugs, aspirin and herbal supplements in the remark section. | ☐ Yes | ☐ No |
| 11. Have you ever used any nicotine or tobacco products? | ☐ Yes | ☐ No |
| If Yes, indicate Type of Product _____ Date of Last Use m m y y y y | | |

REMARKS: Complete this section if you answered "Yes" to any of the questions on the previous page. If you need additional space, attach a separate piece of paper to this application with the proposed insured's signature and date.

| Question No. and Letter | Name and Address of Health Professional | Date/Duration of Illness | Diagnosis/Treatment/Medication |
|---|---|---|---|
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## Section C: Family History (Please provide details in the chart below.)

| | | |
|---|---|---|
| 1. Have your natural parents or siblings ever been diagnosed or treated by a licensed member of the medical profession for: heart or vascular disease, stroke,cerebrovascular disease, diabetes, cancer, or kidney disease? If "Yes," please provide details in the table below. | ☐ Yes | ☐ No |

| Relationship to Proposed Insured | Age of Onset | Age if Living | Age at Death | State of Health (Specific Conditions) or Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |

## Agreement

I, the Proposed Insured, have read the above answers and statements and they: (a) are true and complete to the best of my knowledge and belief and (b) were correctly recorded before I signed this LIFE INSURANCE APPLICATION – PART II. These answers, together with those provided in Part I of the Application and any additional supplements to this application constitutes the entire Application, which will be attached to and made a part of the issued policy. I understand TIAA-CREF Life Insurance Company will rely upon the information provided in the Application to determine whether it will issue the life insurance policy applied for in this Application.

**Fraud Warning**
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.

X_____ _____
Signature of Proposed Insured | Signed at (City, State) | Date

X_____ _____
Signature of Witness | Relationship | Date

## Section D: EXAMINATION (TO BE COMPLETED BY EXAMINER)

The questions which appear below are intended only as a basis for the examination. TIAA-CREF Life Insurance Company relies on its examiners to observe and report all information collected during the examination.

1. a. Height (in shoes) _____ ft. _____ in. b. Weight (clothed) _____ lbs.

c. Did you weigh the proposed insured? ☐ Yes ☐ No

If No, please explain. _____

| 2. Blood Pressure | Initial Reading | 2nd Reading | 3rd Reading |
|---|---|---|---|
| | Systolic _____ | Systolic _____ | Systolic _____ |
| | Diastolic _____ | Diastolic _____ | Diastolic _____ |

3. Pulse at Rest _____

Describe any irregularities _____ Number of irregularities per minute _____

| | | |
|---|---|---|
| 4. Are blood and urine specimens being collected and mailed to the lab? | ☐ Yes | ☐ No |
| Indicate Name of Lab _____ | | |
| 5. Does the Proposed Insured appear unhealthy or older than stated age? If Yes, please explain. If Yes, please explain. _____ | ☐ Yes | ☐ No |
| 6. How long have you known the Proposed Insured? _____ | | |
| 7. Are you related to the Proposed Insured or the agent? | ☐ Yes | ☐ No |
| 8. Are you the Proposed Insured's Primary Care Physician? | ☐ Yes | ☐ No |
| 9. Was the examination conducted in a language other than English? | ☐ Yes | ☐ No |

If Yes, indicate language used and provide name and relation to person acting as interpreter.

Language Used _____

Name of Interpreter _____ Relation to Proposed Insured _____

10. Which Government Issued Picture ID did you verify (Photo Identification required)? Provide the ID number below.

☐ Driver License No. _____ ☐ ID Card _____

☐ Passport _____ ☐ Other (Type) _____

**REMARKS**

## Section D: EXAMINATION (CONTINUED)

**ADDITIONAL REMARKS**

## Medical Examiner's Certification

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.
Name of Proposed Insured

Examined at _____, this _____ day of _____, 20_____, at _____ am/pm

Examiner's Name _____ Type of License _____
Please Print

Examiner's Signature X _____ Examiner's Telephone No. - -

Examiner's SSN/TIN

| Name of Paramedical Company | City | State |
|---|---|---|

730 Third Avenue
New York NY 10017-3206

**TIAA-CREF Life Insurance Company**

# HIV Consent Form

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (TIAA-CREF Life) 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 person.

## Notification of Test Result

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 possible positive test result:

_____

Address:

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 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.

Signature of Proposed Insured or Parent/Guardian _____ Date signed: _____

Name of
Proposed Insured _____ Address _____


Financial Services

## TIAA-CREF LIFE INSURANCE COMPANY

# Authorization for Release of Health-Related Information

**This authorization complies with the HIPAA Privacy Rule.**

Name of Proposed Insured (please print): _____

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to TIAA-CREF Life Insurance Company ("Company"), its agents, employees, representatives and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I also authorize any insurance company, MIB, Inc. ("MIB"), or other organization, institution, or person ("Other Persons") that has any records or knowledge of me or my health, to give to the Company and its agents, employees, representatives and reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

I further authorize TIAA-CREF Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and (4) conduct other legally permissible activities that relate to any coverage I have applied for with TIAA-CREF Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to **TIAA-CREF Life, Attention: Privacy Official, 8500 Andrew Carnegie Boulevard, Charlotte, NC 28262-8500.**

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that TIAA-CREF Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I acknowledge that I have a right to receive a copy of this Authorization.

_____ _____

Signature of Proposed Insured or Personal Representative Date

_____

Description of Personal Representative's authority or relationship to Proposed Insured