TENNESSEE FARMERS LIFE INSURANCE COMPANY
P.O. Box 307 • Columbia, TN 38402-0307

PLEASE PRINT
APPLICATION - PART II MEDICAL

Complete if MEDICAL EXAMINATION is required. The MEDICAL EXAMINER is asked to comment on all "Yes" answers in the "Details" section.

Full Name of Proposed Insured _____ Date of Birth ____ / ____ / ____

1. a. Name and address of your personal physician (if none, so state) _____

_____

b. Date and reason for last consultation _____

_____

c. What treatment was given or medication prescribed? _____

_____

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.)

	Yes	No
2. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, head injury, aneurysm, headaches, speech defect, paralysis or stroke, tremor, muscle weakness, depression, other mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, chronic respiratory disorder or, sleep apnea?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever or other severe infection, heart murmur, heart attack, varicose veins, phlebitis, or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hepatitis, Crohn's disease, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver, gallbladder, pancreas, or spleen?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs?	☐	☐
g. Diabetes, goiter, thyroid, or other endocrine disorders?	☐	☐
h. Neuralgia, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back and joints?	☐	☐
i. Deformity, lameness, or amputation?	☐	☐
j. Disorder of skin or lymph glands, cyst, tumor, or cancer?	☐	☐
k. Allergies, anemia, bleeding tendency, or other disorder of the blood?	☐	☐
l. Disorder, disease or persistent discomfort of the following systems: Immune, e.g., Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)?	☐	☐
m. Testing positive for antibodies to the AIDS (HTLV-III) virus?	☐	☐
3. Other than above, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☐
b. Had a checkup, consultation, illness, injury, surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
d. Had EKG, X-ray, other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
4. Are you now under observation or taking treatment or medication?	☐	☐
5. Have you had any change in weight in the past year?	☐	☐
a. If "Yes," how much? Gain _____lbs., Loss _____lbs.		
b. Give present height _____ft. _____in., weight _____lbs.		
6. a. Do you currently or have you ever used tobacco in any form (i.e. cigarettes, cigars, pipe, chewing tobacco or snuff)?	☐	☐
If "Yes", when did you stop? _____		
Do you currently or have you ever used a nicotine cessation aid such as nicotine gum or patches?	☐	☐
If "Yes", when did you stop? _____		

6. Continued

Have you ever:	Yes	No
b. Used alcoholic beverages? If "Yes," how often and how many ounces? _____	☐	☐
_____ Has use been discontinued? If "Yes," explain.	☐	☐
c. Used narcotics, stimulants, sedatives, hallucinogenics, or any other drugs not prescribed by a physician? If "Yes," what kind and what frequency and amount?	☐	☐
Has use been discontinued? If "Yes", explain.	☐	☐
d. Been arrested and/or treated for any alcohol or drug related problems?	☐	☐
e. Have you ever been arrested and/or convicted for any criminal activity?	☐	☐

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.)

7. Have you ever:	Yes	No
a. Attempted suicide?	☐	☐
b. Had any physical or mental condition resulting in time lost from performing your duties in connection with your employment or military service?	☐	☐
c. Been subject to military service? (Army, Navy, Air Force, Marines, Active or Inactive Reserves, National Guard or Coast Guard) If "Yes", complete Military Questionnaire.	☐	☐
d. Requested or received a pension, benefits, or payment because of an injury, sickness, or disability?	☐	☐
e. Had any company decline to issue, reinstate, or renew a policy; offered a rated or modified policy; or postponed or cancelled any insurance on your life?	☐	☐
f. Had any application or informal inquiry for insurance on your life currently pending in any other company, or have you ever withdrawn such an application or informal inquiry?	☐	☐
g. Had any intentions of flying other than as a passenger or have you flown other than as a passenger during the past 2 years? (If "Yes", complete Aviation Questionnaire.)	☐	☐
h. In the past 2 years engaged in, or do you expect to engage in, racing (automobile, go-kart, cycle, boat, snowmobile) or diving (skin, scuba, sky)? (If "yes", complete Hazardous Activity Questionnaire.)	☐	☐
i. In the past 2 years been refused a driver's license, had a license revoked or suspended, had two or more moving violations, or been involved in one or more automobile accidents? (If "Yes", give details.) (Please provide your driver's license number.)	☐	☐

8. Family History: Is there a history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or suicide? ☐ ☐

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers and Sisters	No. Living_____		
	No. Dead_____		

9. Answer if applicable:

	Yes	No
a. Have you ever had any disorder of menstruation, pregnancy, or of the female organs or breasts?	☐	☐
b. To the best of your knowledge and belief are you now pregnant?	☐	☐

I represent that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, any U.S. Veterans Administration Hospital, insurance company, MIB Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Tennessee Farmers Life Insurance Company, or its reinsurer(s), any such information. A photographic copy of this authorization shall be as valid as the original and is valid for two years of the date of signing.

Tennessee Code Annotated, Title 56 requires that you be advised: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

Signed at _____ this _____ day of _____, _____

_____
Examiner

_____
Proposed Insured

_____
Parent (if Proposed Insured is under age 18)

MEDICAL EXAMINER'S REPORT
PLEASE PRINT

TENNESSEE FARMERS LIFE INSURANCE COMPANY
P.O. Box 307 • Columbia, TN 38402-0307

THE COMPANY WILL NOT PAY FOR ANY ADDITIONAL TESTS THAT GO BEYOND THE REQUIREMENTS OF THIS INSURANCE EXAM.

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

DETAILS of "Yes" answers. (Identify item).

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

c. How did you identify the applicant?

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

e. Are you related to the Proposed Insured? ☐ Yes ☐ No

f. Have you seen the Proposed Insured professionally before this exam? ☐ Yes ☐ No

2. Blood Pressure (Record ALL readings)

(Include additional readings if above 140/90.)

Systolic			
Diastolic 5th Phase			

3. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

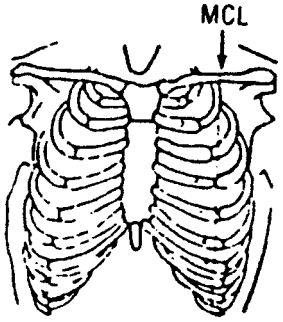
4. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(Describe murmur(s) below - if more than one, describe separately)

LOCATION		
Constant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After Exercise	☐	☐
Increased	☐	☐
Decreased	☐	☐
Unchanged	☐	☐

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by ○
Transmission by →



For comments and your impression or 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?	☐	☐
b. Skin (include scars), lymph nodes, varicose veins or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include liver, spleen, and scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐

5. Continued	Yes	No	DETAILS of "Yes" answers. (Identify item).
g. Endocrine system (include thyroid and breasts)?	☐	☐	
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐	
6. a. Are there any hernias?	☐	☐	
b. Any hemorrhoids?	☐	☐	

7. A specimen of urine must be submitted for analysis as follows:

a.

AGES	AMOUNT OF INS.
0 - 45	$150,000 & OVER
46 - 55	All Volumes
56 & UP	All Volumes

b. There is a history of urinary tract disease.

c. There is diabetes suspected or confirmed, or a family history of diabetes.

d. The initial blood pressure exceeds 150/90.

All specimens must be sent to Lab One, 10101 Renner Blvd., Lenexa, Kansas 66219-9752.

8. Are you aware of additional medical history? ☐ Yes ☐ No
(A confidential report may be sent to the Medical Director)

I performed this examination at ☐ A.M. ☐ P.M. on the _____ day of _____ , _____

Examination made at ☐ my office ☐ individual's office ☐ individual's home ☐ other _____

Examiner's signature: _____

Examiner's address & telephone number: _____

Examining Company Affiliations: _____

PLEASE PRINT **MEDICAL FEE VOUCHER** **DO NOT DETACH**

The Company will pay a reasonable and customary fee for this insurance exam. Payment of your fee will be made from this voucher within 30 days. No additional billing will be necessary. **THE COMPANY WILL NOT PAY FOR ANY ADDITIONAL TESTS THAT GO BEYOND THE REQUIREMENTS OF THIS INSURANCE EXAM.**

Proposed Insured's Name _____ Date of Birth _____ / _____ / _____

Examiner's Name and Address: _____

Examiner's S.S. No. or
Employer I.D. No. _____

Amount of fee for
this insurance exam $ _____

HOME OFFICE USE: AMOUNT $ _____ CODE # _____ METHOD _____

DATE _____ PAID BY _____