UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777
Phone Number: 800-657-6351

STATEMENTS TO THE MEDICAL EXAMINER

(To be completed by Medical Examiner in the presence of the Proposed Insured - Forward completed form to the above address or fax to 1-800-328-0791)

Name: _____ Date of Birth: _____ Gender: ❑ M ❑ F _____

Address: _____ City: _____ State: _____ Zip _____

Occupation _____ Application Date _____

	Yes	No
1. Has any life insurance policy, for which the proposed insured applied, not been issued as applied for?	❑	❑
2. Is the proposed insured currently disabled and / or receiving disability benefits?	❑	❑
3. Within the past 5 years, has the proposed insured had any surgical operation or been under observation or treatment in any hospital, clinic or medical facility?	❑	❑
4. In the past 5 years, has the proposed insured had an X-Ray, Electrocardiogram or any other medical test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	❑	❑
5. In the past 12 months, has the proposed insured used tobacco or nicotine products in any form? If yes, please state type, amount _____. If no, date last used _____	❑	❑
6. Is the proposed insured pregnant? If yes, anticipated delivery date _____ ❑ Vaginal Birth ❑ Cesarean Section	❑	❑
7. Indicate any weight gained or lost in the past year: ❑ Gain _____ pounds ❑ Loss _____ pounds		
8. In the past 10 years, and by a medical professional, has the proposed insured been diagnosed, tested positive or been given medical advise for any of the folowing:		
a. Hypertension; Chest Pain; Heart Attack; Heart Murmur; Heart Arrhythmia; Stroke; TIA; Other disease or disorder of the Heart, Blood Vessels or Circulatory System?	❑	❑
b. Anemia or disease/disorder of the blood; Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); Tested positive for the Human Immunodeficiency Virus (HIV); Other disease/disorder of the immune system?	❑	❑
c. Asthma; Bronchitis; Emphysema; COPD; Other disease/disorder of the lung/respiratory system?	❑	❑
d. Disorder of Thyroid; Endocrine disorders; Kidney; Bladder; Prostate; Breast; Reproductive Organs; Eyes; Ears; Nose; Mouth; Throat?	❑	❑
e. Diabetes; Cirrhosis; Hepatitis; Ulcer; Colitis; Other disease/disorder of the digestive system?	❑	❑
f. Cancer; Lukemia; Lymphoma; Melanoma; Skin Cancer; Other tumors/cysts?	❑	❑
g. Arthritis; Any disorder of the: Muscles, Bones, Joints or Spine?	❑	❑
h. Alzheimer's; Dementia; Epilepsy; Seizures; Disorders of the brain/nervous system, Psychiatric, Mental or Nervous Disorder?	❑	❑
i. To limit /cease consumption of alcohol?	❑	❑
j. For the use of Heroin, Morphine, Cocaine, LSD, Marijuana or abused prescription drugs?	❑	❑
9. In the past 5 years and by a medical professional, facility or treatment center, has the proposed insured recieved treatment for any of the above diseases and disorders? If yes, indicate dates of treatment or counseling, facilites and medical professional(s) names and address. _____	❑	❑
10. In the past 3 years, has the proposed insured received a DWI or DUI or had a driver's license suspended or revoked?	❑	❑
11. In the past 5 years has the proposed insured consulted, been treated or examined by any medical professional for any illness, diesease or injury not included in the answers above? If yes, give details, dates of treatment, and medical professional(s) and/or facility(ies) name, address and telephone number. _____	❑	❑

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.)
If extra space is needed use additional form ICC1230-20A(01-2012).

12. Family Information	Age	Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s) / Sister(s)				

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief. I agree that the company shall rely on these statements and these are to be considered as the basis of the life insurance written. I understand that a copy of this form shall be attached to my policy as part of my initial application. I also understand that 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.

Dated this _____ of _____, _____ at _____, _____
DAY *MONTH* *YEAR* *CITY* *STATE*

_____ Signature of Proposed Insured

_____ Signature of Medical Examiner

PART B **MEDICAL EXAMINER'S CONFIDENTIAL REPORT**

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

Proposed Insured's Name:

2. Did you weigh? ❑ Yes ❑ No Did you measure? ❑ Yes ❑ No

3. Is appearance unhealthy or older than stated age? ❑ Yes ❑ No

Details of "Yes" answers (identify item).

4. **PULSE**	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

5. **BLOOD PRESSURE**	Take three readings, 5 minutes apart		
	READING 1	READING 2	READING 3
Systolic			
Diastolic (5th phase)			

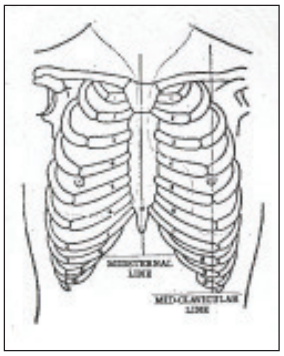
6. Is applicant presently under anti-hypertensive medication? ❑ Yes ❑ No

PHYSICIAN STATEMENT

7. Heart: Enlargement? ❑ Yes ❑ No Dyspnea? ❑ Yes ❑ No
Murmur(s)? ❑ Yes ❑ No Edema? ❑ Yes ❑ No
(Describe below — if more than one, describe separately.)

Location	Murmur 1	Murmur 2
Constant	❑	❑
Inconstant	❑	❑
Transmitted	❑	❑
Localized	❑	❑
Systolic	❑	❑
Presystolic	❑	❑
Diastolic	❑	❑
Soft (Gr. 1-2)	❑	❑
Mod. (Gr. 3-4)	❑	❑
Loud (Gr. 5-6)	❑	❑
After exercise:		
Increased	❑	❑
Absent	❑	❑
Unchanged	❑	❑
Decreased	❑	❑

In diagram below INDICATE Apex by X.
If murmur is present INDICATE
Area of murmur by O.
Points of greatest intensity by 0.
Direction of transmission by ➡



8. Upon examination are there any abnormalities of the following: (check applicable and provide explanation)	Yes	No
(a) Eyes, ears, nose, mouth, pharynx?	❑	❑
(b) Skin; Lymph nodes; Varicose veins or peripheral arteries?	❑	❑
(c) Nervous system; Gait; Reflexes; Paralysis?	❑	❑
(d) Respiratory system?	❑	❑
(e) Stomach or other abdominal organs?	❑	❑
(f) Genitourinary system?	❑	❑
(g) Endocrine system; Thyroid; Breasts?	❑	❑
(h) Musculoskeletal system: spine, joints; Amputations; Deformities?	❑	❑
9. Are there any hernias?	❑	❑
10. Are you aware of additional medical history?	❑	❑

11. Do you rate the risk as: ❑ Excellent ❑ Good ❑ Fair ❑ Bad
If not excellent, Explain: _____

Urinalysis: Specific Gravity	Albumin	Sugar	**IMPORTANT** Please forward urine and/or blood specimen(s) to the Laboratory shown on the container provided.

(a) Is specimen being sent? ❑ Yes ❑ No (b) Blood Study: Is sample being sent to lab shown on container? ❑ Yes ❑ No

I CERTIFY I made this examination in private at ❑ My office, ❑ Applicant's office, ❑ Applicant's home. At_____ ❑ A.M. ❑ P.M.

Dated this _____ of _____, _____ at _____, _____
DAY *MONTH* *YEAR* *CITY* *STATE*

Medical Examiner's Signature: _____

Medical Examiner's Printed Name: _____

Medical Examiner's Address: _____