Part Two

APPLICATION FOR LIFE INSURANCE
UNITED LIFE INSURANCE COMPANY
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

1. Name of Proposed Insured. Print in Full:

2. Date of Birth: Month: Day: Year:

3. Have you ever received disability benefits because of injury or illness?

4. Have you ever applied or been examined for life, accident or health insurance which was declined, postponed or modified as to rate or amount?

5. Have you applied or been examined for life insurance within the past six months? Give name of company and results.

6. HAVE YOU EVER HAD OR BEEN TOLD BY A MEDICAL PRACTITIONER YOU HAD:

	Yes	No
a. Epilepsy, Alzheimer's or Parkinson's Diseases, Paralysis, or ANY Brain, Nervous or Mental Disorder?	❑	❑
b. Pneumonia, Emphysema, Asthma, Chronic Cough, Tuberculosis or ANY Respiratory or Lung Disorder?	❑	❑
c. Chronic Diarrhea or Indigestion, Ulcer, Liver Disease, Colitis, Rectal Disease, or ANY Abdomnal Disorder?	❑	❑
d. Kidney Stone, Albumin or Blood in Urine, Kidney, Bladder, Prostate, or ANY Genito-urinary Disorder?	❑	❑
e. Chest Pain, Heart Attack, Stroke, Heart Disease, Murmur, High Blood Pressure or ANY Heart or Blood Vessel Disorder?	❑	❑
f. Anemia, High Cholesterol, Sugar in your urine or Diabetes?	❑	❑
g. Rheumatic Fever, Arthritis, Gout, Back trouble, or ANY Bone or Joint Disorder?	❑	❑
h. ANY Sexually Transmitted Disease?	❑	❑
i. Cancer, Tumor, or Goiter, or ANY Blood, Gland, Spleen or Skin Disorder?	❑	❑
j. Immune Disorder?	❑	❑
k. Were you ever treated for use of alcohol or drugs and have you ever used narcotics or hallucinogen drugs (except under a physician's care)?	❑	❑
l. Enlarged lymph nodes, unexplained weight loss, Kaposi's sarcoma?	❑	❑
m. Herpes, Candida, Epstein-Barr virus?	❑	❑
n. ANY injury, operation, medical attention or special diagnostic tests (EKG, X-ray, Blood, etc.) not stated above?	❑	❑
7. Have you taken prescription drugs during the last 12 months?	❑	❑

8. Other than above, any examination or treatment by a doctor, practitioner or hospital in the past five years? ❑ Yes ❑ No

9. Have you ever smoked cigarettes? ❑ Yes ❑ No
If so, number of months since you last smoked _____
Do you use any other tobacco products? ❑ Yes ❑ No

10. Family Record (List parents or siblings that died before reaching age 65)

Relationship	Age	Cause of Death
1		
2		
3		

11. Name & Address of personal physician.

Date and reason last seen.

12. What is your: Weight: _____ lb; Height _____ft. _____in.
Have you gained or lost weight in the past year?
Gain_____ lb. Loss_____ lb. Reason for change?

Please give DETAILS of all "YES" answers.
Date—Durations—Results—Doctors' names and addresses

The statements and answers in Part I and Part II of this application are true and complete to the best of my knowledge and/or belief. They are to be considered as the basis on any insurance written hereon. In order to determine eligibility for insurance coverage, of benefits under an existing policy, I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., or Insurance-support organization to give UNITED LIFE INSURANCE COMPANY all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements as concerning the physical and mental condition of myself, my spouse or my minor children. UNITED LIFE INSURANCE COMPANY is free to disclose the data so acquired to its reinsurers, the Medical Information Bureau, Inc., other insurance companies, or any physician designated by me, provided such disclosure is for insuring purposes or involves my continuing health care, or as may otherwise be lawfully required, or as I may further authorize. I acknowledge my right upon demand to obtain a true copy of this authorization from UNITED LIFE INSURANCE COMPANY. This authorization shall be valid for two (2) years from the below date. I agree that a photographic copy of this authorization shall be as valid as the original.

Signed at_____ this _____ day of _____, 20_____

SIGNATURE OF EXAMINING PHYSICIAN

SIGNATURE OF PROPOSED INSURED

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

Please see Medical Examiner's instructions on back of Voucher Stub

13. How long have you known the applicant? _____ Are you related? _____ Are you his/her physician _____

14. Height _____ ft. _____ in. Chest, full expiration _____ in
Chest, full inspiration _____ in.
Weight _____ lb. Abdomen, at umbilicus _____ in.

	YES	NO
Did you weigh?	☐	☐
Did you measure?	☐	☐

Please comment below on any significant gain or loss of weight in past five years.

15. Does inquiry (history) or examination (operative scars, etc.) indicate any past or present disease, function impairment or abnormality of the:

Nervous System? _____ Abdominal Organs? _____ Cardiovascular System? _____

Respiratory System? _____ Genito-urinary System? _____ Glands, Skin, Joints? _____

16. Pulse: Rate per minute: _____ Rhythm: _____ If over 90 or irregular complete #21 below.

17. Blood Pressure:

	1	2	3
Systolic			
Diastolic (5th Phase, end of sound)			

If over 140 or 90 report several readings and complete #19 below.

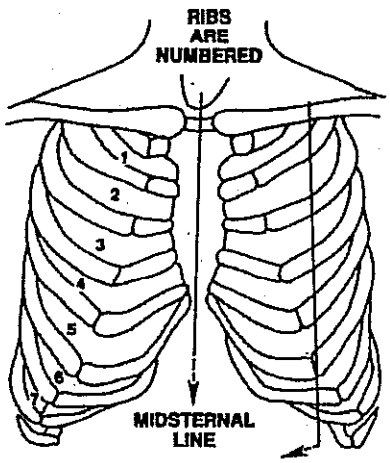
18. Is there evident arteriosclerosis? _____
Is there a heart murmur? _____
Is there any hypertrophy? _____
Is there cyanosis, dyspnea, edema? _____
If any "YES" answers complete #21 below.

19. Is general appearance healthy? _____
Is appearance older than given age? _____
Any eye or ear disease or function impairment? _____
Are there any abnormal reflexes? _____
Is there any deformity or physical defect? _____
Any disorder of prostate? _____
Are there any varicosities? Any hernias? _____

20. Urinalysis: Please send the urinalysis specimen to Home Office Reference Lab in the container provided.

Please give DETAILS and YOUR DIAGNOSTIC OPINION of any "YES" answers

21. HEART SECTION: Please give DETAILS and DIAGNOSTIC OPINION.



MID-CLAVICULAR LINE

PLEASE MARK ON ABOVE DIAGRAM:

X = Apex

O = Maximum intensity of murmur

= Area over which murmur is heard

= Direction of murmur transmission

A. Heart Murmurs:

1. Report Intensity as Grade I to Grade VI.
2. Location?

	YES	NO
Apical Area:	☐	☐
Aortic Area:	☐	☐
Pulmonic Area:	☐	☐
Other	☐	☐

3. Timing?

Systolic:	☐	☐
Presystolic:	☐	☐
Diastolic:	☐	☐

4. Transmission:

Axilla:	☐	☐
Neck:	☐	☐
Scapula:	☐	☐

5. Constant?
6. Effect of exercise?
   Effect of recumbency

B. Hypertrophy?
☐ None ☐ Moderate
☐ Slight ☐ Marked

C. Apex is located in the intercostal space inches to left of the midsternal line.

D. Exercise test: If not done, i.e., contraindicated, please state why. Have applicant do at least 50 vigorous hops or, preferably, 15 ascents on an ordinary chair in one minute in order to secure an adequate exercise response, i.e., an increase of more than 20 beats per minute.

Exercise Test	Pulse Rate	Irregularities Number per min.	Blood Pressure	Murmurs
a. At rest before exercise				
b. After exercise				
c. 3 min. after exercise				
d. 5 min. after exercise (p.r.n.)				

this _____ day of _____ 20_____ A.M. P.M. Signature _____ Examining Physician

Agent _____ Address _____

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. This examination report, once begun, becomes the property of the Company and must not be destroyed or suppressed even if the applicant or anyone else offers to pay the examination fee in order to avoid having the report sent to the Company.
2. Do not examine for the Company anyone who is your relative.
3. Initial any corrections or alterations you make in the report, do not erase.
4. Give a few details and a diagnostic evaluation of any abnormality noted in the applicant's medical history and examination.
5. Complete the #21 Heart Section whenever there is any history, or examination findings indicative of cardiovascular impairment or when the amount of insurance applied for is more than $200,000.
6. Please send urinalysis specimen to Home office Reference lab in the container provided.

LIU-40 (8-93)

VOUCHER STUB

Fees for examinations are paid only through the Home Office. This Voucher Stub should be completed at the time of the examination and mailed by the examiner to:

United Life Insurance Company
P.O. Box 73909
Cedar Rapids, Iowa 52407

Name of Proposed Insured: (Print) _____

Date of Birth: _____ Date of Examination: _____

Name of Agent: (Print) _____

Name of Examiner: (Print) _____

Address of Examiner: _____

Please fill in: $ _____ Fee # _____ Taxpayer Identification

Please record any additional information or comments which would assist the Medical Director to evaluate this applicant.

_____

_____

_____

LIU-40 (8-93)

United Life Insurance Company
P.O. Box 73909
Cedar Rapids, Iowa 52407

Examiner _____
Address _____
_____

Informed Consent

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (United Life) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results is normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this Notice and Consent for Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request to an insurance institution (insurer), agent, or insurance support organization, for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by any insurance institution, agent or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information, and the reasons why I disagree with such refusal to correct, amend or delete recorded personal information.

_____ _____
Please Print Name of Proposed Insured *Date of Birth*

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian *Date Signed* *State of Residence*