USE BLACK INK

MEDICAL EXAMINER'S REPORT

In continuation, and forming a part, of the application for insurance to:

☐ THE WESTERN AND SOUTHERN LIFE INSURANCE CO.

☐ WESTERN AND SOUTHERN LIFE ASSURANCE CO.

A—STATEMENTS TO THE EXAMINER

Proposed Insured _____ (First name / Middle initial / Last Name)

Birth Date: Month Day Year

1. a. Name and address of Proposed Insured's personal physician?
(If none, so state) _____
b. Date and reason last consulted? _____

2. Has the Proposed Insured ever been treated for or ever had:	Yes	No
a. Disorder of eyes, ears, nose or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin or lymph glands; cyst, tumor, or cancer?	☐	☐
k. Allergies; anemia or other disorder of the blood?	☐	☐

3. **Other than above,** has the Proposed Insured within the past 5 years:	Yes	No
a. Had any mental or physical disorder?	☐	☐
b. Had a checkup, consultation, illness, injury, surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
d. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐

4. During his or her entire lifetime, has the Proposed Insured used marijuana, LSD, barbiturates, cocaine, heroin or other narcotic, or other habit-forming drug, or been diagnosed, treated, or advised to be treated for alcoholism or drug use?	☐	☐

5. During his or her entire lifetime, has the Proposed Insured been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex); received treatment from a member of the medical profession for AIDS or ARC; or tested positive for antibodies to the AIDS virus [Human Immunodeficiency Virus (HIV-1) or Human T-Cell Lymphotropic Virus, Type III (HTLV-III)]?	☐	☐

6. Has the Proposed Insured ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐

7. Has the Proposed Insured ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐

8. Any family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	Yes ☐	No ☐

9.	Age if Living	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

10. Has the Proposed Insured used tobacco during the past 12 months?
☐ Yes ☐ No
If "Yes", indicate type of tobacco product used, how much is used, or date when the use of any tobacco product ceased:

11. Dates of last menstrual period?

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.

I hereby declare, before affixing my signature hereto, I read the answers to the above questions, the answers as above written are as given by me in response to the questions; and, to the best of my knowledge and belief, all the answers are complete and true. I further declare no information has been concealed or withheld concerning past or present state of health and habits of the Proposed Insured

Signed at _____ (City) _____ (mm/dd/yyyy) _____ (Medical Examiner Sign as Witness) _____ (Signature of Proposed Insured (if under age 15, Parent or Guardian))

B—STATEMENT OF THE EXAMINER'S FINDINGS

1. a. Height (In Shoes) ft. in.	b. Weight (Clothed) lbs.	c. Has weight changed in the past year? ☐ Yes If "Yes" indicate _____ lbs. Lost ☐ No _____ lbs. Gained

d. Did you weigh? ☐ Yes ☐ No e. Did you measure? ☐ Yes ☐ No
f. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

2. Blood Pressure (Record ALL readings.) — If initial blood pressure is elevated, repeat at end of examination.

Systolic			
Diastolic-5th phase			

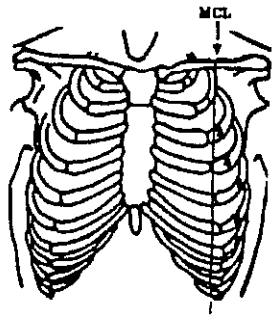
3. a. Pulse rate _____ per min.
b. If pulse rate is 90 or over retake on held inspiration while bending forward. Pulse rate _____ per min.
c. Irregularities in pulse
At rest _____ per min.
After exercise _____ per min.

4. Heart: Do you find any: Murmur(s)
At rest ☐ Yes ☐ No
After exercise ☐ Yes ☐ No
Location of murmur _____ indicate:

Enlargement ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No
Edema ☐ Yes ☐ No

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 ☐

Apex by X
Murmur area by ✿
Point of greatest intensity by 0
Transmission by ♦



For comments and your impression:

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 (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6. (a) Are there any hernias? ☐ Yes ☐ No. (b) Any hemorrhoids?	☐	☐
7. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	☐	☐

Details of "Yes" answers. (Identify Item.)

8. Urinalysis: Albumin | Sugar

Is specimen being sent to laboratory?
☐ Yes ☐ No

9. SEND SPECIMEN TO LABORATORY ONLY IF:
☐ Age 55 or less—Amount $100,000 or over in force plus applied for
☐ Age 56 or over—Amount $25,000 or over in force plus applied for
☐ Abnormal contents on urinary examination, or systolic pressure 150 or higher
☐ History or findings of a cardiac or renal disorder
☐ Home Office request

SPECIAL ATTENTION

REMARKS:

I certify that I made this examination at _____ ☐ A.M. _____ ☐ P.M. DATE _____

Examination made at ☐ My office, ☐ Proposed Insured's office, ☐ Proposed Insured's home, ☐ Other: _____

MEDICAL EXAMINER: PLEASE COMPLETE VOUCHER

RULES FOR MEDICAL EXAMINER

1. Each item of information requested has a bearing on the insurability of the applicant and each question has been most carefully considered before its insertion in the examination form.
2. Ask each question as it is written and be sure that the import of each one is fully understood. Give full particulars on your report when the answer "Yes" or "No" does not cover the information sought.
3. Use black ink.
4. Do not use dashes or ditto marks for answers.
5. If related to Agent or applicant, do not examine.
6. Examinations should be made without Agent present.
7. Do not make "Test" or "Preliminary" examinations.

FORM OD-12-D-9110

TO BE FILLED IN BY MEDICAL EXAMINER

MEDICAL EXAMINER'S VOUCHER
WESTERN-SOUTHERN LIFE, CINCINNATI, OHIO 45202

NAME OF PROPOSED INSURED		DATE OF BIRTH
DATE OF EXAMINATION	NAME OF DISTRICT REQUESTING EXAMINATION	
NAME OF COMPANY EXAMINER OR PARAMEDICAL COMPANY (PLEASE TYPE OR PRINT TO ASSURE PROPER PAYMENT) M.D.		
NUMBER AND STREET		
CITY AND STATE		ZIP CODE

SC / WV / TX

ORDER AND APPOINTMENT FOR MEDICAL EXAMINER

☐ THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY
☐ WESTERN-SOUTHERN LIFE ASSURANCE COMPANY

DATE

DISTRICT _____ ACCT. NO. _____ OFFICE CODE _____

☐ ORDINARY NEW BUSINESS ☐ MAO NEW BUSINESS ☐ POLICY CHANGE ☐ REVIVAL ☐ POLICY NUMBER _____

To Medical Examiner _____ at _____

Name of Person
To be Examined _____ Age _____

Reason for Examination _____

Home Address _____ Phone _____

Business Address _____ Phone _____

Proposed Insured _____

DO NOT DETACH

To be examined at:
☐ Your Office
☐ Residence
☐ Place of Business
Date of Exam _____
Time _____ ☐ A.M. ☐ P.M.
☐ Applicant will phone
☐ Phone Applicant

COMPLETE FOR LIFE ONLY

Face Amt. or Selected Amt. Applied for $ _____
Supp. Term $ _____
Total Amt. Applied for $ _____
Ord. In Force With W-S $ _____
Total $ _____

If total is $100,000 or more for ages 55 and below or $25,000 or more for ages 56 and above, check the proper for the age in section 18 below.

☐ The Western and Southern Life Insurance Company
☐ Western-Southern Life Assurance Company
Cincinnati, Ohio 45202

NOTICE AND CONSENT FOR HIV-RELATED TESTING - TX

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) 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 certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV-related blood 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, you are asked to list your private physician so that the Insurer can have him or her tell you the test results 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 the fact and you request the reason for the denial, the Insurer may require you to name a physician at the 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

RETURN TO NEW BUSINESS DEPARTMENT