

WICHITA NATIONAL LIFE

711 SW D AVENUE • Lawton, Oklahoma 73501 • Phone 1-580-353-5776

Proposed Insured (Please Print)

Birth Date:

Month

Day

Year

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

b. Date and reason last consulted?

c. What treatment was given or medication prescribed?

2. Have you been treated for or had known indication of any of the following? CIRCLE IMPAIRMENT and give details.

a. CARDIO-VASCULAR SYSTEM

Yes No

High blood pressure; artery or vein disorder..... ☐ ☐Heart attack, angina, chest pain, heart murmur..... ☐ ☐

b. ENDOCRINE SYSTEM

Diabetes, thyroid or gland disease..... ☐ ☐

c. RESPIRATORY SYSTEM

Bronchitis, asthma, emphysema..... ☐ ☐

d. DIGESTIVE SYSTEM

Colitis, ulcers, rupture; stomach or intestinal disorder..... ☐ ☐Liver, spleen or gall bladder disease..... ☐ ☐

e. GENITO-URINARY SYSTEM

Disorder of breast, prostate, ovaries, uterus or reproductive organs..... ☐ ☐Sugar, albumin, blood or pus in urine..... ☐ ☐Colic, stones, stricture; kidney or bladder disease..... ☐ ☐

f. MUSCULO-SKELETAL SYSTEM

Arthritis; disorder of muscle, bone, joints or skin..... ☐ ☐

g. EENT SYSTEM

Eye or ear impairment..... ☐ ☐

h. NERVOUS SYSTEM

Hemorrhage, stroke, paralysis..... ☐ ☐Convulsions, dizziness; brain, nervous or mental disorders..... ☐ ☐

i. GENERAL

Cancer, tumor, cyst, blood disorder..... ☐ ☐Any other disease, disorder, injury or physical impairment?.... ☐ ☐

3. Other than as stated above, have you ever: Yes No

a. Consulted or been treated by any physician(s) or practitioner(s) or been hospitalized in past 3 years?..... ☐ ☐b. Had or been advised to have surgical operations, X-ray treatment, Electrocardiogram, X-ray, or other laboratory studies?..... ☐ ☐

4. Do you now use or have you ever used or been treated for usage of:

a. Heroin, Morphine or other narcotic drugs?..... ☐ ☐b. L.S.D., Marijuana, Cocaine or other similar agents?..... ☐ ☐c. Alcoholic beverages to excess?..... ☐ ☐

5. Have you ever:

a. Applied for or received any kind of disability compensation?.. ☐ ☐b. Been declined, postponed or limited for any life or other insurance or reinstatement thereof?..... ☐ ☐6. Have you had an insurance examination done within last 30 days for any other company?..... ☐ ☐7. Has your weight changed in past year?..... ☐ ☐
No. Lbs. _____ Gained? ☐ Lost? ☐8. Are you now taking any medication or treatment?..... ☐ ☐9. Are you in good health and free from impairment?..... ☐ ☐

If question is answered "YES", give full details.

Condition? When? Duration? Results? Doctor(s) or Medical Facility

10. Family History		Age if Living	Age at Death	State of Health or Cause and Date of Death
Father				
Mother				
Brothers and Sisters	No. Living.....			
	No. Dead.....			

I hereby declare that all statements and answers as written herein and in Part One of this application are full, complete and true, whether by my own hand or not, and I agree that they are to be considered the basis of any insurance issued hereon.

Dated at _____ this _____ day of _____, 20____

Witness _____

Examiner

Signature in full of Proposed Insured or Parent or Guardian for Proposed Insured

PART THREE

MEDICAL EXAMINER'S REPORT

This Report is
Confidential Between
Company and Examiner.

To be completed in private
by Examiner only.

Examination of heart and lungs must be with stethoscope against bared skin.

Name

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

1. BUILD

(MALES ONLY):

HEIGHT (IN SHOES)		WEIGHT (CLOTHED)	CHEST (FULL INSPIRATION)	CHEST (FORCED EXPIRATION)	ABDOMEN (AT UMBILICUS RELAXED)
FT.	IN.	LBS.	IN.	IN.	IN.

- a. Did you weigh? ☐ Yes ☐ No b. Did you measure? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

2. BLOOD PRESSURE (Record all readings)

If resting blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided:

	AT REST	AFTER 50 HOPS	3 MINUTES LATER	REPEAT B.P.
SYSTOLIC				
DIASTOLIC 5TH PHASE				
3. PULSE RATE				
Irregularities Per Min.				

4. HEART a. Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder?

☐ Yes ☐ No

b. Is heart enlarged?

☐ Yes ☐ No (If yes, describe)

c. Is murmur present?

☐ Yes ☐ No (If yes, complete 4d)

d. Murmur is:

- ☐ Constant ☐ Transmitted ☐ Presystolic ☐ Apical ☐ Soft (Gr. 1-2)
☐ Inconstant ☐ Localized ☐ Diastolic ☐ Basal ☐ Mod. (Gr. 3-4)
☐ Other ☐ Loud (Gr. 5-6)

After exercise: ☐ Unchanged ☐ Increased
☐ Decreased ☐ Absent

Show Location Of:

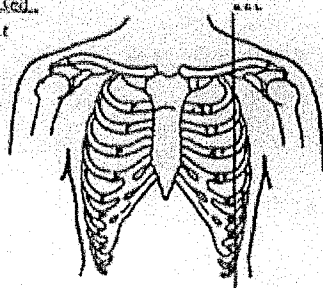
Apex by

Area of murmur by

Point of greatest intensity by

Transmission by

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. Endocrine system (include thyroid and breasts) ☐ ☐
c. Nervous system (include reflexes, gait, paralysis) ☐ ☐
d. Respiratory system ☐ ☐
e. Abdomen (including scars) ☐ ☐
f. Genito-urinary system (include prostate) ☐ ☐
g. Skin (incl. scars), lymph nodes, blood vessels (incl. varicose veins) ☐ ☐
h. Musculoskeletal system (include spine, joints, amputations, deformities) ☐ ☐

6. Are there any hernias, hemorrhoids? ☐ ☐7. Have you any pertinent information not brought out above? ☐ ☐

8. URINALYSIS:

SPECIFIC GRAVITY	ALBUMIN	SUGAR
------------------	---------	-------

Is specimen being sent to Home Office?

☐ Yes ☐ No

Send specimen to Home Office: If Applicant is 51 years of age or over, amount applied for or total amount this Company is over \$100,000, or in case of findings or history of any urinary or circulatory abnormality.

TO EXAMINER: Mail this completed examination directly to:

Wichita National Life Insurance Co.

P.O. Box 1709

Lawton, Oklahoma 73502

I certify that I, _____ made this examination at _____ ☐ A.M. ☐ P.M. on the _____ day
of _____, 20____
Examiner's Name (Please Print)

Where was exam done? _____ Examination authorized by: _____

Examiner's Social Security
or Tax Identification Number must be furnished under authority of law. _____

Examiner's signature _____ Examiner's address _____