1. Name of Proposed Insured _____ Date of Birth _____
2. Height _____ ft. _____ in. 3. Weight _____ lbs.
   If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**
   Name _____
   Address _____
   Telephone _____ Date last seen _____
   Reason last seen and results of visit _____
5. **Physician Last Consulted**
   Name _____ Specialty _____
   Address _____
   Telephone _____ Date last seen _____
   Reason last seen and results of visit _____

	Yes	No
6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below.	☐	☐

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age If Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment. An additional sheet of paper may be attached if necessary.	Yes	No	**Remarks - Explain All Yes Answers** Enter question number before detailed response.
Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:			
7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐	
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?	☐	☐	
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	☐	☐	
15. Any disease or disorder of the prostate or reproductive system?	☐	☐	
16. Any sexually transmitted disorders or diseases?	☐	☐	
17. Pregnancy, complications of pregnancy or infertility? If now pregnant, what is the expected date of delivery? _____	☐	☐	
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	☐	☐	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐	
21. Arthritis or disorder of the bones, skin or muscles?	☐	☐	
22. Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	
23. In the **last 5 years,** unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	☐	☐	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	☐	☐	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	☐	☐	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	☐	☐	
e. Been referred to any other member of the medical profession or medical facility?	☐	☐	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	☐	☐	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	☐	☐	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	☐	☐	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	☐	☐	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?.....	☐	☐	
d. Attended or joined any organization due to alcohol or related problems?	☐	☐	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	☐	☐	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	☐	☐	
27. Have you taken any other medications in the **past 2 years**?..... If Yes, list in Remarks section at right.	☐	☐	
28. Has any person proposed for insurance been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....	☐	☐	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application?..... If Yes, give details. _____	☐	☐	

30. Additional remarks (please indicate which question number remarks reference)

If more room is needed, use page 2 of form #LU-1032 (4/'97)

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

_____ Signed at _____ on ___/___/_____

Signature of Proposed Insured | City/State | Date

William Penn
Life Insurance Company of New York
...A Partnership for Life

PART 3
Medical Examiner's Report

Name of Proposed Insured _____ Date of Birth _____

Instructions to the Examiner -

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

1. Height (in shoes) _____ ft. _____ in.
   Weight (clothed) _____ lbs.

   a. Did you weigh? Yes ☐ No ☐
   b. Did you measure? Yes ☐ No ☐
   If No, please explain _____

2. Measurements (males only)
   Chest (full inspiration) _____ in.
   Chest (forced expiration) _____ in.
   Abdomen (at umbilicus) _____ in.

3. Blood Pressure (record 3 readings)

Systolic			
Diastolic			

4. Pulse At rest _____
   Describe any irregularities (number per minute, etc.)
   _____

5. Are blood and urine specimens being collected and mailed to the lab? Yes ☐ No ☐

IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 6 AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx?	☐	☐	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries?	☐	☐	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)?	☐	☐	
d. Respiratory system?	☐	☐	
e. Stomach, abdominal organs?	☐	☐	
f. Is the liver enlarged or tender?	☐	☐	
g. Genitourinary system?	☐	☐	
h. Musculoskeletal system (including spine, joints, amputations and deformities)?	☐	☐	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.)	☐	☐	

Name of Proposed Insured _____

PART 3 - Medical Examiner's Report (continued)

7. To be completed if number 6.i. is answered Yes or if requested:

	Yes	No	Remarks
a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	☐	☐	
b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?	☐	☐	
c. Are there gallops (S3 or S4)?	☐	☐	
d. Is/are there ejection sound(s) or systolic click(s)?	☐	☐	
e. Is/are there murmur(s) present? If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	☐	☐	
8. a. Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?	☐	☐	
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age?	☐	☐	
9. a. Were you acquainted with the Proposed Insured prior to this examination? If Yes, fully describe the relationship in Remarks.	☐	☐	
b. Are you the Proposed Insured's personal physician?	☐	☐	
c. Was the examination conducted in a language other than English? If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.	☐	☐	
d. Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured?	☐	☐	

10. How did you identify the Proposed Insured? ☐ Driver's license ☐ Other _____

Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.
Name of Proposed Insured

Examined at _____,
Street address, City and State

this _____ day of _____, 20____ at _____ AM/PM.

Print Examiner's name _____ Signature of Examiner _____

☐ Paramed ☐ MD ☐ D.O.

Paramed Company _____ Telephone number _____

Address _____

William Penn
Life Insurance Company of New York
...A Partnership for Life

100 Quentin Roosevelt Boulevard
Garden City, New York 11530

Supplement to Application

Application for insurance dated _____

First Insured _____ Second Insured _____
(Last) (First) (Middle) (Last) (First) (Middle)

"Remarks" continued:
(Show question and number, include dates, and show complete names and addresses where applicable.)

Question #	Please Print - Use Black Ink Only	Question #	Please Print - Use Black Ink Only

I have read the preceding questions and answers; I certify that they are complete and true to the best of my knowledge and belief. I agree that this is a part of the application and shall become a part of any insurance policy issued.

SIGNED AT _____ On _____ 20_____
Town or City, State and Country

Witness _____ _____
Signature of Proposed Insured

_____ _____
Signature of Applicant - Owner