Part II of Application for Individual Life Insurance

ZURICH

Zurich American Life Insurance Company

Administrative Office
7045 College Boulevard
Overland Park, KS 66211-1523

Phone: 877.678.7534
Fax: 888.871.7537
www.zlifeusa.com

Paramedical The following is to be completed by the Proposed Insured (referred to as "you").

1.a. Proposed Insured (Please Print)
First Name _____ Middle Initial _____ Last Name _____

b. Height _____ ft. _____ in. c. Weight _____ lbs. d. Birth Date (MM/DD/YYYY) _____

e. Has your weight changed by more than 10 pounds in the last 6 months? ☐ Yes ☐ No
If Yes, please provide details: _____

2.a. Name and address of personal physician (or medical facility if used instead): (If none, so state) _____

b. Date and reason for last medical or health consultation (within last five years): _____

c. What treatment was given or recommended? (If none, so state) _____

Please provide full details for all "Yes" answers on Page 2.

3.	Are you being treated by diet, drugs or other means?	☐ Yes ☐ No
4.	Have you been diagnosed or been treated by a physician for:	
a.	High blood pressure, chest discomfort, stroke, circulatory or heart disorder?	☐ Yes ☐ No
b.	Diabetes, sugar in the urine, thyroid, or other glandular (endocrine) disorder?	☐ Yes ☐ No
c.	Kidney, bladder, urinary, reproductive organ or prostate disorder?	☐ Yes ☐ No
d.	Protein (albumin), blood or pus in the urine, sexually transmitted disease or venereal disease?	☐ Yes ☐ No
e.	Cancer, tumor, polyp, or disorder of the skin or breast?	☐ Yes ☐ No
f.	Asthma, pneumonia, emphysema, or any other respiratory or lung disorder?	☐ Yes ☐ No
g.	Seizure, convulsion, fainting, loss of consciousness, tremor, paralysis, or other disorder of the nervous system?	☐ Yes ☐ No
h.	Anxiety, depression, stress or any psychological or emotional condition or disorder?	☐ Yes ☐ No
i.	Colitis, hepatitis, ulcers, or other disorders of the stomach, liver or digestive system?	☐ Yes ☐ No
j.	Arthritis, gout, back or joint pain, bone fracture, or muscle disorder?	☐ Yes ☐ No
k.	Anemia, bleeding, or blood disorder?	☐ Yes ☐ No
l.	Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
m.	A positive blood test for antibodies to the HIV virus?	☐ Yes ☐ No
5.	Have you:	
a.	Used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician?	☐ Yes ☐ No
b.	Been treated or counseled for alcoholism or drug abuse?	☐ Yes ☐ No
c.	Been advised to reduce your consumption of alcohol?	☐ Yes ☐ No
6.	Other than previously stated, have you within the past five years:	
a.	Consulted a physician or any other practitioner, had a checkup, illness, surgery or been hospitalized?	☐ Yes ☐ No
b.	Had an electrocardiogram, stress or exercise test, x-ray, blood test or other diagnostic test?	☐ Yes ☐ No
c.	Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed?	☐ Yes ☐ No
7.	Have you, within the last five years:	
a.	Smoked cigarettes? ☐ Yes ☐ No Date of last use? _____	
b.	Used any other form of tobacco? ☐ Yes ☐ No What type? _____	

8. Family History:	Age(s) if Living	Age(s) at Death	Cause of Death
Father			
Mother			
Brother(s) /Sister(s)			

9. Please provide full details for all "Yes" answers to questions 3-6. (Include the dates, the results and the names and addresses of all attending physicians and medical facilities.)

Question	Details

I declare that I have made no statement to the medical examiner, agent, or any other person connected with the Company that in any way qualifies or modifies the above answers and statements. I have read and confirm that the above answers and statements are complete and true to the best of my knowledge and belief. I 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.

Signed at:

City/State

Date (MM/DD/YYYY)

Signature of Proposed Insured

X

Witness (Medical or paramedical examiner will please sign here)

X

Medical Report on Proposed Insured

Name of Proposed Insured _____ Birth Date (MM/DD/YYYY) _____ Age _____

10. Height	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen Relaxed at Umbilicus
ft. in.	lbs.	in.	in.	in.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _____ lbs. ☐ Gain ☐ Loss-Cause

Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (if 140/90 or over, must give at least two additional readings)

	First Reading	Second Reading	Third Reading
Systolic			
Diastolic			

12. Pulse

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities Per Min.			

13. Heart

a Is there any cardiovascular disorder? ☐ Yes ☐ No

b Is heart enlarged? ☐ Yes ☐ No (If Yes, describe) _____

c Is murmur present? ☐ Yes ☐ No (If Yes, complete 12d)

d Murmur is:

☐ Constant ☐ Inconstant

☐ Transmitted ☐ Systolic ☐ Apical ☐ Soft (Gr. 1-2)

☐ Localized ☐ Presystolic ☐ Basal ☐ Mod. (Gr. 3-4)

☐ Diastolic ☐ Other ☐ Loud (Gr. 5-6)

☐ Unchanged ☐ Increased

☐ Decreased ☐ Absent

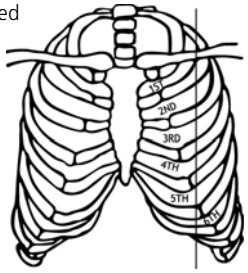
Show location of:

Apex by X

Area of murmur by ○

Point of greatest intensity by O

Transmission by →



e Diagnostic Impression:

14. Is there any abnormality of the following: (Circle applicable items and give details)

a	Eyes, ears, nose, mouth, pharynx (If vision or hearing markedly impaired, indicate degree and correction)	☐ Yes	☐ No
b	Skin (incl. scars): lymph nodes; blood vessels (Incl. varicose veins)	☐ Yes	☐ No
c	Nervous system (Include reflexes, gait, paralysis)	☐ Yes	☐ No
d	Respiratory system	☐ Yes	☐ No
e	Abdomen (Including scars or hernias)	☐ Yes	☐ No
f	Genitourinary system	☐ Yes	☐ No
g	Endocrine system (Include thyroid and breasts)	☐ Yes	☐ No
h	Musculoskeletal system (Include spine, joints, amputations, deformities)	☐ Yes	☐ No

15. Have you any pertinent information not brought out above? ☐ Yes ☐ No

Medical Examiner:

X _____

Signature of Medical Examiner

When paying fees we are required to show and report Social Security or Employer I.D. Number. Please give us this information below.

Include All Hyphens → _____

Examined at: ☐ My Office ☐ Other: _____

Date and Hour of Examination _____ _____ ☐ A.M. ☐ P.M.

Examiner's remarks and description of positive findings:

Identification

Proposed Insured must show acceptable form of identification:

☐ Driver's License ☐ Passport ☐ Green card

☐ Employment I.D. ☐ Other picture/signature I.D.

In my opinion, the item checked is positive identification of Proposed Insured ☐ Yes ☐ No

Proposed Insured speaks and understands the English language ☐ Yes ☐ No

*If either question answered "No," give details of negative reply: