LIFE INSURANCE APPLICATION - PART 2 MEDICAL HISTORY

(NAME OF INSURANCE COMPANY MUST BE INSERTED BEFORE THIS FORM IS USED)

1. PROPOSED INSURED (PI)

First Name:	Legal Residence (No P.O. Box) Line 1:
Middle Name:	Line 2:
Last Name:	City: State: Zip: –
Date of Birth (mm/dd/yyyy)	SSN # / Gov't ID
Case ID	Picture ID Verification ☐ YES ☐ NO Issuing State: ID Type: Expiration Date:

2. PRIMARY CARE PROVIDER Do you have a personal physician or primary care provider? ☐ YES ☐ NO

Physician First Name:	Street Address Line 1:
Physician Last Name:	Line 2:
Facility Name:	City: State: Zip: –
Phone Number:	Date Last Seen:
Reason Last Seen (Diagnosis (Dx) /Symptoms)	Medication/Dosage (Rx) / Treatment (Tx) / Therapy
Tests - Type, Date Results	Remarks

3. MEDICAL CONDITIONS - For any YES answers, please complete MEDICAL CONDITION DETAILS on page 3, Section 6 and/or Supplement if additional space is required.

Within the past (10) ten years have you been advised of, been treated for, had any known indication of or been diagnosed by a medical professional with:

	YES	NO		YES	NO
1. Disorder of the Eyes, Ears, Nose or Throat	☐	☐	28. Sexually Transmitted Disease	☐	☐
2. Persistent Headaches, Migraines	☐	☐	29. Diabetes or Glucose Intolerance	☐	☐
3. Dizziness	☐	☐	30. Disorder of the Pancreas	☐	☐
4. Elevated Blood Pressure	☐	☐	31. Other Endocrine Disorders (e.g. Thyroid,		
5. Chest Discomfort	☐	☐	Adrenal, Pituitary)	☐	☐
6. Irregular Heartbeat	☐	☐	32. Blood Transfusion	☐	☐
7. Heart Attack or Angina	☐	☐	33. Anemia or other Blood Abnormality	☐	☐
8. Heart Murmur	☐	☐	34. Cancer or Malignant Tumor	☐	☐
9. Disorder of Heart or Blood Vessels	☐	☐	35. Leukemia or Lymphoma	☐	☐
10. Stroke or Transient Ischemic Attack	☐	☐	36. Benign Tumor or Polyp	☐	☐
11. Shortness of Breath	☐	☐	37. Connective Tissue Disorder (e.g. Lupus, Scleroderma)	☐	☐
12. Asthma	☐	☐	38. Paralysis	☐	☐
13. Sleep Apnea	☐	☐	39. Rheumatoid Arthritis	☐	☐
14. Emphysema or Chronic Bronchitis	☐	☐	40. Back / Spine / Neck Disorder	☐	☐
15. Allergies	☐	☐	41. Muscle Disorder	☐	☐
16. Other Lung or Respiratory Disorder	☐	☐	42. Sciatica, Neuritis	☐	☐
17. Disorder of the Esophagus	☐	☐	43. Other Bone or Joint Disorder	☐	☐
18. Ulcer or other Digestive Disorder	☐	☐	44. Alcohol Counseling or Treatment	☐	☐
19. Disorder of the Intestines, Colon or Rectum	☐	☐	45. Alcoholism	☐	☐
20. Crohn's Disease or Ulcerative Colitis	☐	☐	46. Drug Counseling or Treatment	☐	☐
21. Hepatitis	☐	☐	47. Suicide Attempt	☐	☐
22. Other Liver Disorder	☐	☐	48. Panic Attack	☐	☐
23. Kidney Disorder	☐	☐	49. Depression	☐	☐
24. Urine Abnormality	☐	☐	50. Seizures or Neurological Disorder	☐	☐
25. Bladder Disorder	☐	☐	51. Other Mental or Nervous Disorders	☐	☐
26. Pregnancy Complications	☐	☐	52. Any Other Disease, Disorder or Condition not		
27. Disorder of Reproductive Organs or Breast	☐	☐	mentioned above.	☐	☐

4. ADDITIONAL MEDICAL INFORMATION - For any YES answers, please complete MEDICAL CONDITION DETAILS on page 3, Section 6 and/or Supplement if additional space is required.

Within the last (5) five years in addition to the information already given, have you had any other:

	YES	NO		YES	NO
53. X-Rays, Cat Scan, MRI	☐	☐	58. OB / GYN Exam	☐	☐
54. Electrocardiogram Including Stress Test or Treadmill	☐	☐	59. Job Physical	☐	☐
55. Blood Test	☐	☐	60. General Physical	☐	☐
56. Urine Test	☐	☐	61. Other Care exam	☐	☐
57. Other Medical test (Not including HIV {Human Immunodeficency Virus} Test)	☐	☐	62. Surgery or Hospitalization	☐	☐
			63. Treatment, Therapy Care or Prescription Medicine	☐	☐

64. Are you currently pregnant? If "Yes" list due date: ______________________________ ☐ YES ☐ NO

65. Have you been advised to have or do you plan to have hospitalization, surgeries or diagnostic tests that have not yet been completed? ☐ YES ☐ NO

66. Has there been a weight change of ten (10) pounds or more within the last 12 months? ☐ YES ☐ NO

If yes, what was your weight 12 months ago ? ______________ Present weight: _______________
Reason for weight change:

67. Within the last ten (10) years have you been diagnosed as having and/or been treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or HIV (Human Immunodeficiency Virus) infection? ☐ YES ☐ NO

68. Do you participate in a regular exercise program? ☐ YES ☐ NO

69. Have you ever had military service deferred or rejected? ☐ YES ☐ NO

70. Other than as prescribed by a physician, do you or have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? If YES, give name, form, amount, frequency and length of use, and date last used. ☐ YES ☐ NO

71. Tobacco or Nicotine Use - Date last used any form of tobacco or nicotine:

☐ Cigarettes (mm/yyyy): ______________________
Number of packs per day: ______________________
☐ Pipe (mm/yyyy): ______________________
☐ Cigar (mm/yyyy): ______________________
☐ Nicotine Patch (mm/yyyy): ______________________
☐ Nicotine Gum (mm/yyyy): ______________________
☐ Chewing Tobacco (mm/yyyy): ______________________
☐ Never Used ☐ Other (mm/dd/yyyy): ______________________

5. BIOLOGICAL FAMILY CENSUS

Have any of these individuals developed any of the diseases listed below? If "Yes" provide details below.

Relation	Gender	Age if Living	Age at Death	Cause of Death	
A. Father					☐ YES ☐ NO
B. Mother					☐ YES ☐ NO
C. Sibling 1					☐ YES ☐ NO
D. Sibling 2					☐ YES ☐ NO
E. Sibling 3					☐ YES ☐ NO
F. Sibling 4					☐ YES ☐ NO
G. Sibling 5					☐ YES ☐ NO

Relation	Heart Disease	Kidney Disease	High Blood Pressure	Diabetes	Mental Illness or Suicide	Cancer
	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age
	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age
	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age
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	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age	☐ YES ☐ NO ____ Onset Age

6. MEDICAL CONDITION DETAILS

Physician First Name:	Medical Condition Identifier Specifiy Item # from Section 3 or 4:
Physician Last Name:	Still Under Treatment ? ☐ YES ☐ NO
Last Treated (mm/yyyy):	Last Episode (mm/yyyy):
Reason Last Seen (Diagnosis (Dx) / Symptoms)	Medication (Rx) / Treatment (Tx) / Therapy
Tests - Type, Date Results	Additional Information / Complications / Activity Limitations / Recovery

Physician First Name:	Medical Condition Identifier Specifiy Item # from Section 3 or 4:
Physician Last Name:	Still Under Treatment ? ☐ YES ☐ NO
Last Treated (mm/yyyy):	Last Episode (mm/yyyy):
Reason Last Seen (Diagnosis (Dx) / Symptoms)	Medication (Rx) / Treatment (Tx) / Therapy
Tests - Type, Date Results	Additional Information / Complications / Activity Limitations / Recovery

FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO, FL, HI, MD, NE, NY, OH, OK, OR, VA or VT)

In FLORIDA, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In VIRGINIA and MARYLAND, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may have violated state law.

I agree that these statements are a part of my application for insurance and that all statements and answers: (a) are complete and true to the best of my knowledge and belief and (b) will be relied on to determine my insurability.

Dated at: _____ (Time) ☐ am ☐ pm This: _____ (Day (dd)) Day of: _____ (Month (mm)) In the Year: _____ (Year (yyyy))

_____ (Signature of Witness)

_____ (Proposed Insured (Signature of Proposed Insured))