Globe Life And Accident Insurance Company

Medical Questionnaire

(to be completed by the Medical Examiner in his own handwriting, signed in his presence and witnessed by him.)

Print first, middle and last names of Proposed Insured.	Sex	Birthdate Mo.	Day	Yr.

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. Do you have or have you ever been treated for or ever had any known indication of:	Yes	No
a. Disorder of eyes, ears, nose or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, epilepsy, 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, 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 or reproductive organs?	☐	☐
g. Diabetes, thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Tumor, cancer or disorder of skin or lymph glands?	☐	☐
k. Allergies, anemia or other disorder of the blood?	☐	☐
l. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) or tested positively for antibodies to the HIV (AIDS) virus?	☐	☐
3. Except as prescribed by a physician: a. Have you within the past 5 years used barbiturates, sedatives or tranquilizers?	☐	☐
b. Have you ever used LSD, marijuana, heroin, morphine, cocaine or any other controlled substance?	☐	☐
4. In the past 5 years have you used alcoholic beverages to intoxication, or have you been treated for alcoholism or any drug habit?	☐	☐
5. a. Have you used tobacco in any form within the last twelve months?	☐	☐
b. If you have been a tobacco user and quit, when did you quit? Enter month and year on this line: _____		
6. Are you now under observation or taking treatment?	☐	☐
7. Have you had any change in weight in the past year?	☐	☐
8. **Other than above,** have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☐
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, blood test or other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
9. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
10. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
11. Have you ever had any disorder of menstruation, pregnancy or of the reproductive organs or breasts?	☐	☐

12. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	Yes	No
	☐	☐

	Age if Living	Cause of Death?	Age at Death
Father			
Mother			

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.)

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce Globe Life And Accident Insurance Company to issue this policy or contract applied for.

Dated at _____ (City) _____ (State) Date _____

Witness _____ (Signature of Medical Examiner) _____ (Signature of Proposed Insured)

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Medical Examiner's Report
This examination should be made in private. If third person present, give details.

13. a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

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

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

14. Blood Pressure (Record all readings. If first reading is borderline or elevated, take a second reading.)

Systolic: _____ Systolic: _____
Diastolic: _____ Diastolic: _____

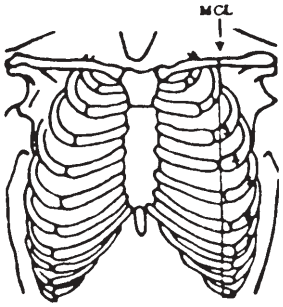
15. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

16. Heart: Is there any: Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(Describe below — If more than one, describe separately)

Location		
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	☐	☐

Indicate:
Apex by ×
Murmur area by ◌
Point of greatest intensity by ○
Transmission by ◗



For comments and your impression:

17. 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 (include 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 (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
18. (a) Are there any hernias? ☐ Yes ☐ No (b) Any hemorrhoids?	☐	☐
19. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

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

REFER TO GLOBE LIFE'S MEDICAL REQUIREMENTS CHART

If a Blood Profile is required, are you sending one? **Yes** ☐ **No** ☐

FEES:
EXAM $_____

ALSO, IF APPLICABLE:
BLOOD PROFILE $_____
OTHER (Specify) $_____

To facilitate payment please print name and address where check is to be mailed. (If Para-Medical use Company stamp.)

20. Urinalysis by the Examiner (Required with each exam)

Specific Gravity	Albumin	Sugar

*Is specimen being sent to laboratory? ☐ Yes ☐ No

***NOTICE: You are to send the urine specimen in a urine container to our laboratory if any one of the following apply: (1) coverage is for over $50,000; (2) applicant is over age 60; or (3) there is any G-U history or abnormal urine findings. If a Blood Profile is being sent, use the urine container in the kit. DO NOT SEND A SECOND SPECIMEN. DO NOT MAIL SPECIMEN TO THE GLOBE LIFE HOME OFFICE.**

I certify that I made this examination _____ ☐ A.M. ☐ P.M. on the _____ day of _____, _____ (Year)

Examination made at ☐ my office, ☐ Individual's office, ☐ Individual's home, ☐ Other: _____

I have known the applicant _____ years as a _____ (Patient, Friend, Relative) Requested by _____ (Agent's or Manager's Name)

Examiner's address: _____ Examiner's Signature: _____

Declaration

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce Globe Life And Accident Insurance Company to issue this policy or contract applied for.

AIDS Testing Information

To evaluate your insurability, Globe Life And Accident Insurance Company (the Insurer) has requested that you provide a sample of your blood 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 tests will be performed by certified laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-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.

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

A positive test result will be disclosed to a physician you designate. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result:

_____ Address: _____

City, State, Zip _____

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above.

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.

_____ _____
Name of Proposed Insured | Signature of Proposed Insured or Parent/Guardian

_____ _____
Address | Date Signed

_____ Witness: _____
Signature of Medical Examiner

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AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Globe Life And Accident Insurance Company or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

Date _____ _____ _____
Witness | Signature of Proposed Insured