Grange Life Insurance Company

650 South Front Street, PO Box 1218, Columbus, Ohio 43216-1218

Part 2 of Application for Insurance
MEDICAL EXAMINATION

Policy No. _____

1. Name of Proposed Insured	2. Occupation	3. Date of Birth

4. Family Record	If Living		If Deceased		
	Age	State of Health	Age	Year of Death	Cause of Death
Father					
Mother					
Brothers / No. Living ___ No. Dead ___					
Sisters / No. Living ___ No. Dead ___					

For Wisconsin Applicants Only: Test results of AIDS/HIV received at anonymous counseling and testing sites or results received from a home test kit need not be disclosed. All tests must be FDA licensed.

5. In the past 10 years, have you ever been treated for, or to the best of your knowledge and belief ever had any disease of: (Answer each separately)	Yes	No	If "Yes", give name of disorder, dates, results, name and address of attending physician.
A. The Brain or Nerves, Anxiety, Depression, or any Mental or Nervous Disorder?	☐	☐	
B. The Nose, Tonsils, Throat or Lungs?	☐	☐	
C. Chest Pain or elevated Blood Pressure?	☐	☐	
D. The Heart or Blood Vessels?	☐	☐	
E. The Stomach, Liver, Intestines, Kidney or Bladder?	☐	☐	
F. The Genito-Urinary System?	☐	☐	
G. The Skin, Bones, Glands, Thyroid, Eyes or Ears?	☐	☐	
H. The Rectum? (Hemorrhoids, Fistula)	☐	☐	
I. The Breast or Pelvic Organs?	☐	☐	
J. Gout, Arthritis or Rheumatic Fever?	☐	☐	
K. Diabetes, Epilepsy, Tuberculosis, Syphilis or Asthma?	☐	☐	
L. Ulcer, Colitis or Dysentery?	☐	☐	
M. Vertigo or Dizzy Spells?	☐	☐	
N. Cancer, Leukemia, or Tumor of any kind?	☐	☐	
O. Sugar, protein or blood in urine?	☐	☐	
6. Have you ever been medically diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome ("AIDS") or AIDS Related Complex ("ARC")?	☐	☐	
7. Have you ever tested positive for HIV?	☐	☐	
8. A. Have you ever been under treatment or observation in any hospital?	☐	☐	
B. Have you ever had a surgical operation scheduled or completed ?	☐	☐	
C. Are you maimed or deformed in any way?	☐	☐	
D. Have you in the past 10 years had any other illness, or injury not mentioned elsewhere?	☐	☐	
E. Is there a family history of diabetes, heart disease or cancer?	☐	☐	
9. Do you now use or have you ever used any habit-forming drug or narcotic?	☐	☐	

10. How many alcoholic beverages do you consume daily ____ weekly ____?

11. Have you ever been treated for drug addiction, alcoholism or been a member of AA?	☐	☐
12. A. Do you use tobacco in any form?	☐	☐

B. If "Yes" what? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing ☐ Snuff Daily usage _____

C. Have you used tobacco in any form in the past and quit? ☐ Yes ☐ No Last date used _____
What? _____

13. Are you to the best of your knowledge and belief now in good health? ☐ Yes ☐ No

14. State every physician or practitioner whom you have consulted, or who has treated you, during the past five years. If none, so state.

Name and Address of Each	Dates and Details	Result

15. Give name and address of your personal physician.

16. I hereby represent to the best of my knowledge that all statements and answers as written or printed herein and in Part 1 of this application are full, complete and true, whether written by my own hand or not. I agree that they are to be considered the basis of any insurance issued hereon.

I hereby authorize any physician, surgeon, hospital or clinic to give the MEDICAL DIRECTOR of the GRANGE LIFE INSURANCE COMPANY, all information concerning my condition including history, physical and laboratory findings, diagnosis, treatment, and prognosis at any time prior to and including the date of this authorization. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date shown below.

17. Signed at _____ (City) _____ (State) this _____ day of _____, 20 ___

WITNESS _____ (Examiner's Signature)

_____ (Signature of Proposed Insured)

Part 3. MEDICAL EXAMINER'S REPORT

1. A. How long have you known Proposed Insured?

B. Are you related in any way to Proposed Insured or Agent? Which one and how related?

2. A. Does Proposed Insured impress you as being healthy?

_____

B. What is the apparent age? _____

3. A. Pulse rate. Count full minute — A.

B. Is pulse intermittent or irregular? if "Yes", describe _____ — B.

4. Do you know of anything in connection with the moral character, drinking habits, smoking habits (or physical condition not already detailed) which would affect their insurability?

5. A. Exact height? (in shoes)

B. Scale weight? (in ordinary clothing)

C. Weight one year ago?

D. Girth of Chest? Forced insp. Forced exp.

E. Girth of abdomen at greatest circumference

6. Blood pressure? Systolic _____

Diastolic _____ (Disappearance of sound)

7. URINALYSIS:

Is specimen authentic? _____ Specific gravity? _____

Protein _____ Test Used? _____

Sugar? _____ Test Used? _____

NOTE: A specimen must be sent to the Home Office if:

A. Sugar or protein is found.
B. History of GU disorder, glycosuria, albuminuria, or if B.P. exceeds 150/100.
C. Amount applies for is $100,000 or more.
D. Applicant is over age 60.
E. Two or more cases of diabetes in the family.

Are you sending a specimen to the Home Office? ☐ Yes ☐ No

I have examined _____ in private at his (or her) residence/my office

this ___ day of _____, 20 ___, and witnessed his (or her) signature herein.

Time of Examination: _____ a.m. _____ p.m. Agent requesting examination _____

Examiner's Name _____ Examiner's Phone # _____

Examiner's Address _____

Examiner's Signature _____