Medical History Questionnaire
Group Division Underwriting

Minnesota Life Insurance Company - A Securian Company
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MINNESOTA LIFE

Please Print: Proposed Insured's Name (Last, First, Middle Initial)	*Date of Birth (Mo, Day, Year)*

	YES	NO
1. A. Have you ever smoked cigarettes?	☐	☐

Current smoker	Past smoker	Packs per day	Date last cigarette smoked (mo., day, yr.)
☐	☐		

B. Have you ever used tobacco, other than cigarettes, in any form?	☐	☐

What type	Current user	Past user	How much	Date of last use (mo., day, yr.)
	☐	☐		

NOTE: GIVE DETAILS TO ALL YES ANSWERS IN SPACE PROVIDED.

2. In the past 10 years, have you been treated for or advised that you had any of the following:		
A. Any disease or disorder of your brain or nervous system including paralysis, fainting spell, seizure, headaches, meningitis, dizziness; depression; nervous, emotional, psychiatric or anxiety disorder?	☐	☐
B. High blood pressure, stroke, heart attack, angina or chest pain, rheumatic fever, heart murmer, irregular heartbeat or any other disease or disorder of your heart or blood vessels?	☐	☐
C. Emphysema, shortness of breath, chronic cough, pneumonia, asthma, lung or sleep disorder?	☐	☐
D. Colitis, cirrhosis, bleeding from your intestines, diarrhea, uncer or hernia, gallbladder, abdominal pain, hepatitis or any other disorder of your stomach, liver or intestines or pancreas?	☐	☐
E. Protein or blood in your urine; kidney stone; any disorder of your kidneys or bladder?	☐	☐
F. Disorder of your prostate, overies, uterus or breasts; complication of pregnancy, genital herpes, syphilis, gonorrhea or other sexually transmitted disease?	☐	☐
G. Cancer, leukemia, tumor, cyst or enlarged lymph notes?	☐	☐
H. Diabetes; sugar in urine, blood disorder, thyroid or other glandular disorder?	☐	☐
I. Arthritis, bursitis, gout, sciatica, pain or disorder of your back, neck, spine, muscles, bones or joints?	☐	☐
J. Any physical deformity or defect; any disorder of your eyes, ears, nose or throat?	☐	☐
K. Have you ever been diagnosed as having AIDS, ARC or any disorder of your immune system; or had a blood test showing evidence of antibodies to the AIDS virus (positive HIV)?	☐	☐
L. Any chronic or recurrent fever, fatigue or viral illness?	☐	☐
3. A. During the past 10 years, have you been advised to limit your use of or seek treatment for alcohol, chemical or drug usage or been a member of Alcoholics Anonymous?	☐	☐
B. Have you tried or used cocain, heroin, marijuana, barbiturates or other controlled substances?	☐	☐
C. Do you consume alcoholic beverages? If yes, what kinds, how much, and how often?	☐	☐
4. During the past 2 years, have you been absent from work for a period of more than five consecutive days because of illness or injury, or received workers compensation benefits or disability benefits of any kind?	☐	☐
5. Other than above, have you in the past five years:		
A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.)	☐	☐
B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility?	☐	☐
C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test?	☐	☐
D. Been advised to have any test, hospitalization, or surgery which was not completed?	☐	☐

YES NO

6. Family History: *Make a note of diabetes, cancer, melanoma, stroke, heart, and kidney disease, including age at diagnosis.*

		Current Age(s)	Health History With Age at Diagnosis		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

7. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below ☐ ☐

Name	Telephone number

Address (street, city, state, zip code)

Date last seen	Reason

GIVE DETAILS OF ALL YES ANSWERS, including doctors' names, addresses and dates. Use next page if additional space is required.

Any person who, with the 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.

I have read the statements and answers recorded on this questionnaire; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Date	Witness	Signature of proposed insured
		X

SUPPLEMENT TO QUESTIONNAIRE

I have read the statements and answers recorded on the questionnaire; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Date	Witness	Signature of proposed insured
		X

Examiner's Report

MINNESOTA LIFE

A. 1. Height in shoes FT. IN. | 2. Weight clothed LBS. | 3. Did you weigh? ☐ Yes ☐ No | 4. Did you measure? ☐ Yes ☐ No

5. Weight change in past year? LBS. ☐ Gain ☐ Loss | Cause? | 6. Measure waist (relaxed) IN.

B. Cardiovascular Examination:

1. After careful examination, do you find any evidence of past or present disorder of heart or blood vessels or any sign of arteriosclerosis?
☐ YES ☐ NO

2. Blood Pressure
If systolic reading is over 140 or diastolic is over 90, take a second reading at the end of examination. (record both readings)

	1st reading	2nd reading
a. Systolic	_____ mm	_____ mm
b. Diastolic - 5th phase (Disappearance of sound)	_____ mm	_____ mm

3. Examine heart before and after exercise (15 bends) in upright and recumbent positions. Do not exercise if contra-indicated.

Pulse (seated)	At Rest	After Exercise	After 5 Min.
a. Rate per minute			
b. Irregularities per minute			

C. 1. Is heart enlarged? ☐ Yes* ☐ No | 2. Is murmur present? ☐ Yes* ☐ No | * *If yes, please complete section H "Cardiac Exam"*

D. Is there on examination any abnormality of the following: (circle applicable items and give details)

	YES	NO
1. Eyes, ears, nose, mouth or pharynx	☐	☐
After examining eye grounds, do you find evidence of disease?		
Type _____		
Circle appropriate grade: 1, 2, 3, or 4		
2. Skin, (include scars); lymph glands; varicose veins	☐	☐
3. Nervous system (include reflexes, gait, paralysis)	☐	☐
4. Respiratory system	☐	☐
5. Abdomen (including scars)	☐	☐
6. Genitourinary system (include prostate)	☐	☐
7. Endocrine system (include thyroid and breasts)	☐	☐
8. Musculoskeletal system (include spine, joints, amputations, deformities)	☐	☐

E. Does this person impress you as being in normal health? ☐ ☐

If no, explain: _____

F. Urinalysis

Specific gravity	Albumin	Sugar

Check appropriate box and send specimen only if:

- ☐ Requested by agent.
- ☐ Parent and/or sibling diabetic.
- ☐ History of renal disease.
- ☐ Abnormal findings on dipstick analysis.

G. 1. How long and how well have you known the applicant?

_____

2. Where was this examination made? _____

3. If requested, are you sending ☐ ECG, ☐ X-ray or

☐ Other test? _____

H. Cardiac Exam: *To be completed if abnormality of heart size or murmur is found.*

1. Describe the murmur(s) in terms of timing, loudness, location, character and transmission.

_____

_____

_____

_____

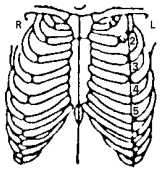
2. Locate:

Apex by **X**

Area of murmur by outline ⋰⋱

Point of greatest intensity by ●

Transmission by ➞



3. Your impressions? _____

_____

DETAILS:

Name _____ M.D.

Address _____

City | State | Zip code

Signature

X _____ M.D.