Prudential

MODIFIED EXAMINATION

POLICY NUMBER (IF KNOWN): _____

ON THE LIFE OF
PROPOSED INSURED: _____

This form contains confidential information about the person you have examined. Do not give this form or any copy of it to anyone outside Prudential.

INSTRUCTIONS TO THE EXAMINER

Important

After this form has been completed, mail it directly to the Home Office at once. Do so regardless of the findings on the person examined and even if you are unable to fully complete the form.

NOTE: Verify identification by photo ID.

Mail the urine specimen to the laboratory if <u>any</u> of the following conditions are present:

1. Medical Examination Appointment Slip indicates a urine specimen requirement in either the Examination Information or the Additional Remarks section.
2. Albumin or sugar is indicated on the dipstick analysis of the urine specimen.
3. Systolic blood pressure of more than 140 mm. Hg., or diastolic of more than 90.
4. History of :
    a. Hypertension.
    b. Abnormal urinary findings or disease of genito-urinary system.

Always record three blood pressure readings

VOUCHER

It is important that this voucher be fully and properly completed.

1. Name of person examined: _____
2. Date of birth: ____/____/____ 3. Social Security number: _____
4. Name of examiner: _____
5. Tax number: _____
6. Address of examiner: Street _____ Apt _____
   City _____ State _____ ZIP _____
7. Date of examination: ____/____/____
8. Amount of insurance: $_____
9. Name of writing representative: _____ 10. Field office_____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Fee – Please indicate your fee for the service(s) provided.

Exam $_____ ECG $_____ Lab $_____ X-Ray $_____

Total $_____

FOR PRUDENTIAL USE ONLY

Fee – Please indicate your fee for the service(s) provided.

☐ A400 ☐ A470 ☐ A852 ☐ A892 ☐ _____

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED: _____

EXAMINER'S CONFIDENTIAL REPORT

A. Examination was done at:

☐ Home ☐ Business ☐ My office

B. Time of day examined: _____AM _____PM.

C. Height: _____ft. ____in. Did you measure? ☐ Yes ☐ No

D. Weight (in clothes): _____ lbs. Did you weigh? ☐ Yes ☐ No

E. Blood pressure:

	Systolic	Diastolic	Arm	Time Taken *(Include AM/PM)*
1st reading:	_____	_____	☐ Left ☐ Right	_____
2nd reading:	_____	_____	☐ Left ☐ Right	_____
3rd reading:	_____	_____	☐ Left ☐ Right	_____

Always record three blood pressure readings taken at intervals. Mail us a urine specimen if systolic is over 140 or diastolic is over 90.

F. Pulse: At rest (seated)

Pulse rate per minute	Premature contractions No. per minute

1. If lowest rate exceeds 100, repeat observations later in examination.
2. Any irregularities other than premature contractions? ***(If yes, describe below.)*** ☐ Yes ☐ No

G. Are there any abnormalities of: *(Record all details below)*

1. Eyes (*retinopathy, retinal changes)?* ☐ Yes ☐ No
2. Blood vessels (pedal pulses, bruits)? ☐ Yes ☐ No
3. Respiratory organs (including nose, throat and mouth)? ☐ Yes ☐ No
4. Abdominal organs (including tenderness, scars, organomegaly, bruits)? ☐ Yes ☐ No
5. Nervous system? ☐ Yes ☐ No

Note: Examine heart in upright, recumbent and left lateral recumbent positions.

H. Heart – any murmur present? ☐ Yes ☐ No
(If yes, give details below.)

1. Murmur details
   ☐ Apical ☐ Basal ☐ Other
   ☐ Systolic ☐ Diastolic
   ☐ Barely heard-Gr.1 ☐ Faint-Gr.2 ☐ Mod-Gr.3
   ☐ Loud-Gr.4 ☐ Very loud-Gr.5 ☐ Loudest possible-Gr.6
   ☐ Transmitted ☐ Localized
2. Effect of body position: _____
3a. Is heart enlarged? ☐ Yes ☐ No
   b. Any other abnormal cardiac findings? ☐ Yes ☐ No
   (If either is yes, describe below.)
4. What is your diagnosis or opinion?

_____

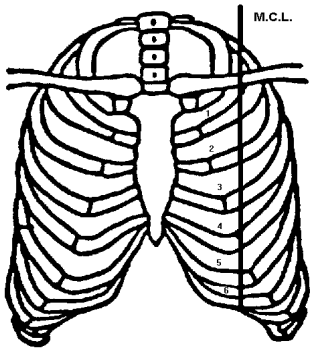
5. Mark position of apex; location of murmur(s) and transmission on diagram.

Position of apex beat **X**

Area of distribution of murmur

Point of maximum intensity of murmur

Direction of transmission of murmur →



I. Analysis of urine:
Are you mailing us a urine specimen? ☐ Yes ☐ No
Mail a specimen, if required by instructions on cover.)
Albumin ☐ Yes ☐ No
Sugar ☐ Yes ☐ No
(*If either is yes, mail us a portion of the urine examined.)*

J. Female only: Current menses? ☐ Yes ☐ No

K Is the person examined your patient? ☐ Yes ☐ No
(If yes, and if any information was not disclosed, submit office records.)

L. Have you any information about this person not recorded elsewhere on this form relating to physical or mental impairment? ☐ Yes ☐ No

Give details of all yes answers to Questions F(2), G, H 3a-b, and L

_____

_____

_____

_____

_____

_____

I secured the required picture identification of the person examined. ☐ **Yes** ☐ **No**

I certify that on the date below, I examined the person named above. ☐ **Yes** ☐ **No**

SIGNATURE

➔ Signature of examiner **X** _____ Date of examination _____

Street, city, state, ZIP _____