Medical Examination - Part 1

AccordiaLife
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Accordia Life and Annuity Company
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Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE & NAME:

(In this application, "Company" refers to the insurance company named above)

Name of Proposed Insured	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yy) / /
Social Security Number	Name of Agent	

Medical History Recorded By Examiner (Answers are to be completed by Examiner)

A. MEDICAL PROFESSIONAL CONTACT INFORMATION

1. Contact information for your medical professional(s) or health care provider(s):

Name and Title	Address	Phone Number

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

3. Are you currently taking prescribed or over-the-counter medications? If yes, please list below. . . . . ☐ Yes ☐ No

B. MEDICAL INFORMATION

1. Height in shoes ft. in.	Weight in clothes lbs.

2. Have you gained or lost more than 10 pounds in the last year? . . . . . ☐ Yes ☐ No
3. Are you now under observation or treatment by a medical professional? . . . . . ☐ Yes ☐ No
4. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? . . . . . ☐ Yes ☐ No
5. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? . . . . . ☐ Yes ☐ No
6. Have you ever been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? . . . . . ☐ Yes ☐ No
   b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? . . . ☐ Yes ☐ No
   c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? . . . . . ☐ Yes ☐ No
   d. Diabetes, thyroid, glandular or endocrinal disorder? . . . . . ☐ Yes ☐ No
   e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? . . . . . ☐ Yes ☐ No
   f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? . . . . . ☐ Yes ☐ No
   g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? . . . . . ☐ Yes ☐ No
   h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? . . . . . ☐ Yes ☐ No

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B. **MEDICAL INFORMATION** (continued)

i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No

j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No

k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No

7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No

8. Within the last 5 years, other than noted in previous questions, have you:

a. Seen a doctor, health care provider, counselor, therapist, or had any illness as diagnosed by a member of the medical profession, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? ☐ Yes ☐ No

b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No

c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been counseled or treated by a member of the medical profession, or been convicted or plead guilty to a crime related to alcohol, controlled substance or drug abuse, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No

9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No

10. Do you currently use alcoholic beverages? ☐ Yes ☐ No

If yes, what is the average number of drinks per day? _____

11. Are you pregnant? ☐ Yes ☐ No If yes, please provide delivery date: ___/___/___

12. Have any of your parents or siblings been diagnosed or treated by a member of the medical profession for diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No

13. Family information (biological parents, siblings):

Family Member	Gender	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				

Provide complete details of any yes answers to questions B.2-B.12. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional

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B. **MEDICAL INFORMATION** (continued)

14. Do you exercise regularly (aerobic, calisthenic, jogging or running, swimming)? . . . . . ☐ Yes ☐ No

If yes, describe and state how often:

15. a. Do you use any form of tobacco or nicotine based products? . . . . . ☐ Yes ☐ No

b. If no, have you used any form of tobacco or nicotine based products in the last 5 years? . . . . . ☐ Yes ☐ No

c. If yes, when did you last use tobacco or nicotine based products?

Mo./Yr. Last Used: Type: Quantity:

B. **SIGNATURES**

It is represented that the answers and statements on this application are complete and true and correctly recorded.

I agree that a copy of this application shall be a part of the policy.

I authorize any physician, medical practitioner, hospital, clinic, pharmaceutical database, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me including information about drug use, alcoholism, HIV, or mental illness and any other non-medical information about me to give to Accordia Life and Annuity Company (the "Company"), its reinsurers or its authorized representatives any such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I agree that this authorization shall be valid for 2 years from the date shown below and that a photographic copy of this authorization shall be as valid as the original.

Signed/Dated at City, State	Signature of Examiner X
On Date	Signature of Proposed Insured X

Medical Examination - Part 2

A. **PHYSICAL EXAMINATION** (Questions 1-3 to be completed on all examinations)

1.

a. Measured Height (in shoes)	ft.	in.
b. Scale Weight (clothed)		lbs.

Chest Full Inspiration inches	Chest Forced Expiration
Waist Measurement	Hip Measurement

2. Blood Pressure
Arm, sitting - take 2 readings and record both. If a reading is higher than 140/90, record 2 more readings at end of examination.

a. Initial Readings						b. Later Readings					
1	Systolic		2	Systolic		3	Systolic		4	Systolic	
	Diastolic (5th phase)			Diastolic (5th phase)			Diastolic (5th phase)			Diastolic (5th phase)	

3. Pulse at rest sitting...

Rate per minute	Describe irregularities and give number per minute

If lowest pulse rate is over 90, record an at-rest rate at end of examination here:

(Questions 4-6 to be completed by qualified Physician upon carrier request)

4. Any Heart Murmur? ☐ Yes ☐ No

If yes, provide description of murmur:

a. Location: ☐ Apical ☐ Aortic ☐ Pulmonic:	d. If transmitted, where?
b. Timing: ☐ Holosystolic ☐ Midsystolic ☐ Diastolic	e. Does squatting or valsalva maneuver affect the murmur? ☐ Yes ☐ No
c. Character: ☐ Rough ☐ Blowing ☐ Other: _____ Grade: ☐ 1-2 ☐ 3-4 ☐ 5-6	f. Is murmur heard: ☐ Left Lateral? _____ ☐ Supine? _____ ☐ Sitting? _____ ☐ Standing? _____

g. If more than 1 murmur, describe separately here:

h. Your diagnosis of murmur(s):

5. Other Cardiac Findings — Is/are there any:

a. Evidence of cyanosis, clubbing, dyspnea, edema or enlargement? . . . . . ☐ Yes ☐ No
If enlarged, give location of left border:

b. Carotid bruit or absence of pedal pulses? . . . . . ☐ Yes ☐ No
c. Abnormality of veins? . . . . . ☐ Yes ☐ No
d. Any other cardiac abnormality? . . . . . ☐ Yes ☐ No
e. If any above are yes, what is your diagnosis or opinion?

Medical Examination - Part 2

A. **PHYSICAL EXAMINATION** (continued)

6. General Examination — Is there any abnormality of:
   a. Ears or eyes? ☐ Yes ☐ No
   b. Nose, mouth, throat or lungs? ☐ Yes ☐ No
   c. Skin, musculoskeletal system or amputations? ☐ Yes ☐ No
   d. Neurologic system (include paralysis, reflexes)? ☐ Yes ☐ No
   e. Endocrine or lymphatic systems? ☐ Yes ☐ No

   Provide complete details of any yes answers to questions 6.a-6.e in question 3 below.

B. **GENERAL INFORMATION** (To be completed for all examinations)

1. Was an interpreter used to complete this form if the Proposed Insured cannot speak or understand English? ☐ Yes ☐ No

Interpreter name	Relationship of Interpreter

2. Miscellaneous Information
   a. Are you aware of any additional medical history or findings? ☐ Yes ☐ No
      (A confidential report may be made to the Company's Medical Director or details may be provided in question 9)
   b. Is appearance that of good health? (If no, describe in question 9). ☐ Yes ☐ No
   c. Are you related to or have a business association with either the Proposed Insured or the Agent?
      (If yes, describe in question 3). ☐ Yes ☐ No
   d. Are you the Proposed Insured's personal physician? ☐ Yes ☐ No
      If yes, for how long? _____ years

3. Additional Medical History and Comments:

4. Blood and Urine Specimens - should be based on the amount of insurance applied for

$100,000 — up	Draw blood samples and collect urine specimen using the provided blood kit and send kit (with blood and urine samples) to designated lab.
$10,000 — $99,999	Collect urine specimen and send to designated lab in provided specimen container.

Indicate handling: ☐ Blood and urine sent to lab ☐ EKG tracing attached
☐ Urine only sent to lab

I certify that I have questioned and examined the Proposed Insured.

Proposed Insured's full name	, of	Proposed Insured's Address (City and State)

Date of exam	Time of exam	☐ AM ☐ PM	Place of exam

Signature of examiner X	Please be sure the Proposed Insured has signed Part 1 and the examiner has signed both Parts 1 and 2. Please see Company instructions for mailing.
FEE Information. Send fee to: (please use stamp or print legibly, include taxpayer no.)	

If any additional studies required by the Company were done, indicate what was done and send tracing or film with the exam form.