PART II OF APPLICATION TO

☐ THE BALTIMORE LIFE INSURANCE COMPANY ☐ LIFE OF MARYLAND, INC.

QUESTIONS TO BE ANSWERED BY THE APPLICANT TO THE MEDICAL EXAMINER.

Proposed Insured _____ Birth Date _____
First Name Middle Initial Last Name Day Month Year

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. Have you ever had medical treatment for:	Yes	No
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, 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, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gall bladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, male or female reproductive organs, breasts?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	☐	☐
k. Allergies; anemia or other disorder of the blood?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐
m. Any mental or physical disorder not listed above?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. *Other than above,* have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
c. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide	☐	☐

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

9. Have you been diagnosed by a member of the medical profession for:	Yes	No
a. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)* or any other immunological disorder?	☐	☐
b. Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or unexplained infections?	☐	☐

*AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.

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.)

It is hereby represented that the statements and answers in all parts of this application are true, complete and correctly recorded, to the best of my knowledge and belief.

I hereby authorize ANY PHYSICIAN, HOSPITAL, CLINIC, INSURANCE COMPANY OR OTHER ORGANIZATION, INSTITUTION OR PERSON, that has any records or knowledge of me or my health, to give to The Baltimore Life Insurance Company any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original.

Date _____

Witness _____ M.D. _____

Form 364-690 *Medical Examiner* *Signature of Applicant*

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. When an Examination is begun, the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation.
2. An Examiner is not permitted to examine his own relative or cases for an agent who is a relative.
3. Any erasures or alterations in your report should be initialed by you.
4. Make your report complete and detailed, since the Medical Director must base his judgment largely on your pen picture of the applicant. **Answer every question**. If answer is negative, write "No" or "None;" if positive, give full details.
5. Special confidential information may be written on a separate sheet and submitted directly to the Home Office.

MEDICAL EXAMINER'S VOUCHER

Name of Applicant _____ Fee $ _____

Address _____ _____

_____ Name of Medical Examiner *(Please Print)*

Date of Examination _____ Address _____

_____

Mail your report and this voucher to the Home Office of the Company. The fee for this examination will be in accordance with the fee schedule; see card inserted in "Instructions and Information for Medical Examiners" pamphlet.

(See Instructions on Reverse Side)

FOR HOME OFFICE USE District Date Paid **DO NOT DETACH**

MEDICAL EXAMINER'S REPORT

1. BUILD AND MEASUREMENTS
   - A. Height _____ft. _____ins. Measured? ☐ Yes ☐ No
   - B. Weight _____lbs. Weighed? ☐ Yes ☐ No
   - C. Chest Inspiration _____ins. Expiration _____ins.
     Abdomen at umbilicus _____ins.

2. BLOOD PRESSURE *(Take three readings at rest—3 minutes apart)*

Systolic			
Diastolic			

3. Record results of exercise test (25 hops on each foot) unless contraindicated.

	Before Exercise	After Exercise	After 3 Mins. Rest
Pulse Rate			
Number of Irregularities			

Any chest pain or undue dyspnea, during or after exercise? ..... ☐ Yes ☐ No

4. DO YOU FIND any evidence of past or present abnormalities or disease of:
   - A. Brain or nervous system? ..... ☐ Yes ☐ No
     (Test pupillary and patellar reflexes, Note gait. Any paralysis?)
   - B. Ears, eyes, nose or throat? ..... ☐ Yes ☐ No
   - C. Glands? (Thyroid, lymph, endocrine) ..... ☐ Yes ☐ No
   - D. Lungs or other respiratory organs? ..... ☐ Yes ☐ No
   - E. Heart or blood vessels? ..... ☐ Yes ☐ No
   - F. Stomach or other abdominal organs? ..... ☐ Yes ☐ No
   - G. Genito-urinary system? (Including prostate) ... ☐ Yes ☐ No
   - H. Bones, joints or skin? ..... ☐ Yes ☐ No

5. IS THERE:
   - A. A Hernia? ..... ☐ Yes ☐ No
     If "Yes," is it reduceable? ..... ☐ Yes ☐ No
   - B. Evidence of varicose veins or ulcers? ..... ☐ Yes ☐ No
   - C. Deformity, loss of limb or lameness? ..... ☐ Yes ☐ No

6. GENERAL
   - A. How well do you know examinee? _____
   - B. Have you ever treated the examinee or been consulted by him/her? ..... ☐ Yes ☐ No
   - C. Do you find that the examinee has any physical or mental defect, or is in ill health? ..... ☐ Yes ☐ No
   - D. Do you believe the examinee is older than the age given? ..... ☐ Yes ☐ No
   - E. Have you reason to suspect that the examinee is or has been an intemperate user of alcohol or a user of narcotics? ..... ☐ Yes ☐ No

7. URINALYSIS:

Specific Gravity	Albumin	Sugar

Is specimen being sent to Home Office? ..... ☐ Yes ☐ No

Send Specimen to Home Office if:

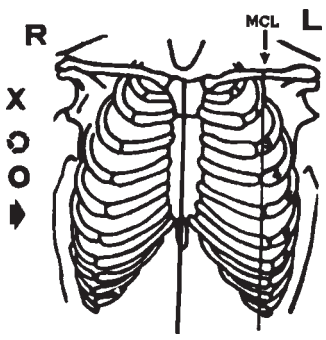
A. History or examination findings indicate cardiovascular or genitourinary impairment, hypertension, diabetes or diabetic family history.

B. Albumin or sugar in the examination specimen.

C. Amount of insurance is $100,000 or more to age 30, $60,000 or more to age 60, the applicant is over age 60.

8. HEART
   - A. Is there a murmur ..... ☐ Yes ☐ No
     If Yes, give details below
     Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic
     Intensity: ☐ Faint ☐ Moderate ☐ Loud
     Quality: ☐ Soft ☐ Blowing ☐ Rough
     Location: ☐ Apex ☐ Base
   - B. How is murmur affected by:
     Respiration? _____
     Exercise? _____
     Recumbency? _____
   - C. Is murmur transmitted ..... ☐ Yes ☐ No
     If Yes, where _____
   - D. Degree of hypertrophy:
     ☐ None ☐ Slight ☐ Moderate ☐ Marked
   - E. Is there evidence of decompensation? ..... ☐ Yes ☐ No
   - F. Is there a thrill? ..... ☐ Yes ☐ No
   - G. Is murmur: ☐ Organic ☐ Functional ☐ Unsure

Locate
apex by
area of murmur by outline
point of greatest intensity by
transmission by



H. What is your final impression?

_____

_____

DETAILS OF "YES" ANSWERS. *(Identify item.)*

Dated at ☐ my office, ☐ applicant's home, ☐ applicant's place of business; at _____

this ___ day of _____, 19 ____ Signature of Examiner _____ M.D.

_____
(Please Print or Stamp Name)

_____
Address

_____