Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Statement to Examiner to Supplement Life Insurance Application

First Name	Middle Initial	Last Name	Maiden Name/Former Name	Month Day Year
Proposed Insured Legal Name				Birth Date / /
Street		City	State ZIP Code	Social Security Number
Legal Residence Address				

1. Does the Proposed Insured currently have a personal physician? ❑ **Yes** ❑ **No**
If answered "Yes," please list details below. If more space is needed, provide answers in number 10 of this application.

Name, Address, and Telephone Number of Personal Physician	Date Last Seen	State Reason, Findings and Treatment

2. Has the Proposed Insured ever been diagnosed or treated as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) by a member of the medical profession? ❑ **Yes** ❑ **No**

3. Has the Proposed Insured ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:

	Yes	No
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	❑	❑
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath? ..	❑	❑
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	❑	❑
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	❑	❑
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?.....	❑	❑
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	❑	❑
(g) any disease, or disorder of vision, or hearing?	❑	❑
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder?.....	❑	❑

4. In the past 10 years, has the Proposed Insured:

	Yes	No
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?	❑	❑
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	❑	❑
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?	❑	❑

5. In the past 12 months, has the Proposed Insured:

	Yes	No
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	❑	❑
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	❑	❑
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	❑	❑
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?.....	❑	❑

– continued –

6. In the past two years, has the Proposed Insured, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? ❑ **Yes** ❑ **No**

If answered "Yes", please list details below. If more space is needed, provide answers in number 10 of this application.

Medication Name (Copy from Pharmacy Label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage Frequency

7. In the past five years, has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? ❑ **Yes** ❑ **No**

If answered "Yes", please list details below. If more space is needed, provide answers in number 10 of this application.

Medical Impairment, Injury, Illness or Results of Testing, or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

8. Has the Proposed Insured ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? ❑ **Yes** ❑ **No** **If "Yes," to question 8, please list details below.**

Form of Tobacco/Nicotine Replacement Therapy	Number per Day	Date Stopped

9. Family History – Please list details below for the Proposed Insured, or if not applicable check here ❑

	Age at Death	**If Deceased, Cause of Death**
Father		
Mother		
Sibling 1		
Sibling 2		

10. List details of "Yes" answers. Identify question number and provide any additional information necessary. If more space is needed, use additional sheet of paper.

I agree that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied on by Companion Life Insurance Company to determine insurability.

Signed at: _____ _____ Date _____
City State Mo Day Yr

Witness _____ _____
Signature of Examiner Signature of Proposed Insured

This form is to be attached to and made a part of the application.

Confidential Medical Report

Mail Direct to: Companion Life Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

Applicant Name: _____
Print Name

11. (a) Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

11. (b) Did you weigh? ..... Yes ❑ No ❑
(c) Did you measure? ..... Yes ❑ No ❑
(d) Was blood drawn? ..... Yes ❑ No ❑

Blood Pressure (Record ALL readings.) Repeat readings if elevated.

12.				
	Systolic			
	Diastolic Fourth phase			
	Fifth phase			

13.	At Rest	After Exercise	3 Minutes Later
Pulse			
Rate			
Irregularities per min.			

14. Is appearance unhealthy or older than stated age? ..... Yes ❑ No ❑
15. Are there any signs of frailty (weight loss, exhaustion, weakness, slow walking speed, low physical activity, difficulty standing up or impaired balance)? ..... Yes ❑ No ❑
16. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.) ..... Yes ❑ No ❑

This section is to be completed only by a medical doctor (if required).

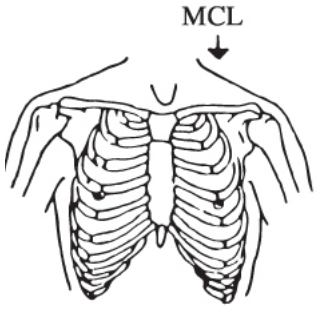
17. Heart: Is there any:

Enlargement? Yes ❑ No ❑	Dyspnea? Yes ❑ No ❑	Murmur(s)? Yes ❑ No ❑	Edema? Yes ❑ No ❑

(Describe below — if more than one, describe separately.)

Location	Murmur No. 1	Murmur No 2.
Constant	❑	❑
Inconstant	❑	❑
Transmitted	❑	❑
Localized	❑	❑
Systolic	❑	❑
Presystolic	❑	❑
Diastolic	❑	❑
Soft (GR. 1-2)	❑	❑
Mod. (Gr. 3-4)	❑	❑
Loud (Gr. 5-6)	❑	❑
After exercise	❑	❑
Increased	❑	❑
Absent	❑	❑
Unchanged	❑	❑
Decreased	❑	❑

Indicate:
Apex by: X
Murmur area by: ..... Φ
Point of greatest Intensity by: ..... O
Transmission by: ..... ➡



For comments and your impression

18. Is there on examination any abnormality of the following: (Circle applicable items and give details.)
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) .. Yes ❑ No ❑
(b) Skin (include scars); varicose veins, peripheral arteries, discolorations, open sores or rash? ..... Yes ❑ No ❑
(c) Lymph nodes? ..... Yes ❑ No ❑
(d) Nervous system (include reflexes, gait, paralysis)? ..... Yes ❑ No ❑
(e) Respiratory system? ..... Yes ❑ No ❑
(f) Abdomen (include scars)? ..... Yes ❑ No ❑
(g) Genitourinary system (include prostate)? ..... Yes ❑ No ❑
(h) Endocrine system (include thyroid and breasts)? ..... Yes ❑ No ❑
(i) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... Yes ❑ No ❑

19. Did your examination reveal any condition requiring further investigation or immediate treatment? ..... Yes ❑ No ❑
(If "Yes," did you advise the Proposed Insured or refer the Proposed Insured to his or her personal physician? ..... Yes ❑ No ❑

List details of "Yes" answers to questions 14 through 19. Identify question number and use additional sheet if necessary.

Time of examination _____a.m. _____p.m. Place: ❑ Your Office ❑ Other (Explain) _____
Amount of Insurance $ _____ Name of Agent _____ Agency Name _____

EXAMINER _____ SIGNATURE _____
Please Print Name Title Title

ADDRESS _____ _____
Street City State ZIP Code Mo Day Year