Horace Mann
Educated Financial Solutions

Horace Mann Life Insurance Company

1 Horace Mann Plaza
Springfield, Illinois 62715-0001

Supplemental Medical Application for life insurance

Name, address and birth date of person examined (Please print)

Name _____ (Last) | _____ (First) | _____ (Middle)

City _____ State _____ ZIP _____ Birth date _____

Medical History Within the last ten years have you had any disease or disorder as follows:

	Yes	No
1. a. Heart or blood vessels?	[ ]	[ ]
b. Blood, blood pressure, or immune disorder?	[ ]	[ ]
c. Stroke or heart murmur?	[ ]	[ ]
d. Chest pain or shortness of breath?	[ ]	[ ]
e. Abnormal heart rate or arrhythmia?	[ ]	[ ]
2. a. Lungs or bronchi?	[ ]	[ ]
b. Tuberculosis?	[ ]	[ ]
c. Pleurisy, asthma, sarcoidosis, or emphysema?	[ ]	[ ]
3. a. Esophagus, stomach or intestines?	[ ]	[ ]
b. Liver or gallbladder?	[ ]	[ ]
c. Ulcer or colitis?	[ ]	[ ]
4. a. Genito-urinary system?	[ ]	[ ]
b. Kidneys or bladder?	[ ]	[ ]
c. Sugar, pus, albumin, blood or casts in urine?	[ ]	[ ]
d. Prostate?	[ ]	[ ]
5. a. Brain or nervous system?	[ ]	[ ]
b. Dizziness or unconsciousness?	[ ]	[ ]
c. Depression, anxiety, epilepsy or paralysis?	[ ]	[ ]
d. Encephalitis, multiple sclerosis, or neuritis?	[ ]	[ ]
6. a. Diabetes or gout?	[ ]	[ ]
b. Thyroid or glands?	[ ]	[ ]
7. a. Skin, muscles, bones or joints?	[ ]	[ ]
b. Arthritis or lupus?	[ ]	[ ]
c. Fibromyalgia?	[ ]	[ ]
8. Eyes or ears; uncorrected visual defect; impaired hearing?	[ ]	[ ]
9. Tumor or cancer?	[ ]	[ ]
10. Alcoholism or drug abuse?	[ ]	[ ]
11. Weight change in past year?	[ ]	[ ]
12. Breast, uterus, tubes or ovaries?	[ ]	[ ]
13. Are medications currently being taken?	[ ]	[ ]
14. Tobacco or nicotine used within last 36 months?	[ ]	[ ]

15. Other than the above, have you in the past 5 years:

a. Had an x-ray, electrocardiogram or other diagnostic test or been advised to do so?	[ ]	[ ]
b. Had surgery or been a patient at a hospital, clinic, emergency room or other medical facility?	[ ]	[ ]
c. Had any other illness, injury, check-up or consultation?	[ ]	[ ]

16. Personal physician? (Name, address, date last seen, and for what reason). _____

17. Explanation for any question answered "Yes." For tobacco, indicate in what form, how often, and how much. (List question # and give dates, severity, outcome, names and addresses of physicians, hospitals or clinics and other pertinent details.)

It is agreed that my answers are correctly recorded and that the Supplemental Medical Application will be included with my pending application for insurance and also of any subsequent application made by me within four months from date hereon for insurance in this company unless I then undergo another medical examination which by its terms is made a part of such application and of subsequent applications.

_____ Date _____
Signature of Proposed Insured

Medical examiner (Witness) _____

Phone # _____

Medical examiner's report to be filled out in private

Name _____ Date of birth _____ Policy number _____

Must measure and weigh applicant. Sex_____ Height (in flat shoes) _____ ft. _____ in. Weight (clothed) _____lbs.
Measurements (males only) Chest (inspiration) _____ in. (expiration) _____in. Abdomen (at waist) _____ in.
Do you consider applicant to be in good health?_____ Is applicant deformed?_____
Are you related to the proposed insured or agent? _____Which one and how related? _____

Blood pressure
Systolic _____
5th phase diastolic _____
If B.P. exceeds 140/90, additional reading at end of examination_____

Pulse rate
_____/ min. If rate exceeds 90, additional reading at end of exam._____/ min.
Is there any arrhythmia? _____If so, number _____/min.
Number after exercise (pulse at least 100 per min.)_____/min.

Urinalysis
Albumin _____ Sugar _____
Are you forwarding a specimen of the proposed insured's urine to the laboratory? _____

Important — Mail specimen of urine to lab when:
There is a history of Genito-urinary disease.
Either albumin or sugar is found on this examination.
Blood pressure is above 145/95 mm.

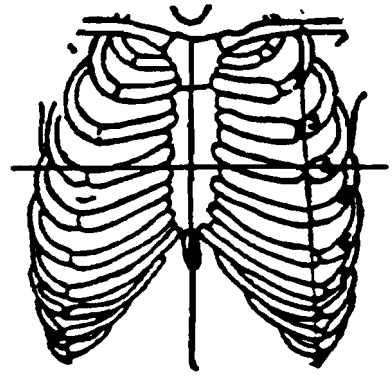
This section to be completed by M.D. This section does not need to be completed if this is a paramedical exam.

Eyes, ears, nose or throat _____
Lungs _____
Abdominal organs _____
Endocrine system _____
Reflexes _____
Lymphatic system _____
Skin _____
Genito-urinary system _____
Is there evidence of vascular disease, arteriosclerosis, varicosities, etc.?_____

Is there any murmur? No ___ Yes ___ If so, complete this section.

Circle word in each line which is most suitable.
(a) **Time:** Systolic Presystolic Diastolic
(b) **Quality:** Harsh Soft Musical
(c) **Volume:** Grade I II III IV V VI
(d) **Pitch:** High Low
(e) **Transmitted** **Not transmitted**
(f) **Constant** **Inconstant**
(g) **Hypertrophy:** None Slight Moderate Marked

On chart indicate quadrant of chest in which murmur is most audible. If transmitted, indicate direction by arrow.



What is your diagnosis?

Remarks and details of positive findings

I certify that I have carefully examined _____ whose signature is affixed on the Supplemental Medical Application. The examination was made in private on _____ (date) at _____a.m. _____p.m.
☐ at my office ☐ proposed insured's residence ☐ proposed insured's place of business ☐ Other _____

_____ _____
(Medical examiner) (Please print) (Mailing address of medical examiner and ZIP code)

_____ _____
Signature of examiner ☐ M.D. ☐ PMT ☐ R.N. ☐ Other (Phone #)

Name of agent requesting examination _____ Amount of insurance applied for $ _____

Examiners are requested to forward all medical forms directly to Horace Mann Life Insurance Company, 1 Horace Mann Plaza, Springfield, Illinois 62715 immediately upon completion of examination and under no circumstances deliver same to agents.