INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific Insurance
and Financial Services Inc.
P.O. Box 19009, Greenville, SC 29602-9009
Tel: (866) 363-3290 FAX: (866) 368-0095

PART 2
OF APPLICATION

1. Name of Proposed Insured: _____ Date of Birth: (M M / D D / Y Y Y Y) Sex: ❑ M ❑ F

2. a) Name and address of your usual physician or medical facility:

b) Date and reason last consulted:

c) Results, diagnosis, and/or treatment prescribed:

	Yes	No
3. In the past ten years, have you had, been tested for, received treatment or counseling from a medical professional for:		
a) Dizziness, fainting, convulsions, seizures, epilepsy, speech disorder, paralysis, stroke, or severe headaches?	❑	❑
b) Depression, anxiety, mental or nervous disorder?	❑	❑
c) Shortness of breath, bronchitis, emphysema, tuberculosis, asthma, spitting of blood, pleurisy, or persistent cough?	❑	❑
d) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack, or coronary artery disease?	❑	❑
e) Rheumatic fever, heart murmur, heart valve disorder, edema, or disorder of the heart or blood vessels?	❑	❑
f) Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, intestines, spleen, liver, or rectum?	❑	❑
g) Diabetes, high blood sugar, or sugar in your urine?	❑	❑
h) Blood cells, albumin, or protein in your urine, any disorder of the kidneys, bladder, prostate, or urinary system?	❑	❑
i) Venereal disease or any disorder of the reproductive system?	❑	❑
j) Thyroid, thymus, pituitary, or lymph gland disorder?	❑	❑
k) Cancer, sarcoidosis, tumor, or any abnormal growth?	❑	❑
l) Back pain, sciatica, neuritis, rheumatism, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?	❑	❑
m) Multiple sclerosis, or any disorder of the brain or spinal cord?	❑	❑
n) Hemophilia, sickle cell anemia, anemia, or any disorder of the blood?	❑	❑
o) Alcoholism, or excessive use of alcohol or drugs?	❑	❑
4. In the past ten years, have you:		
a) been diagnosed or treated by a physician or other health care professional as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC), or positive test results indicating the presence of the AIDS virus?	❑	❑

Details of "YES" answers:
(Please identify applicable question and include dates, diagnosis, duration, treatment, as well as the full name and address of all physicians and medical facilities.)

		Yes	No	Details of "YES" answers: (Please identify applicable question and include dates, diagnosis, duration, treatment, as well as the full name and address of all physicians and medical facilities.)
5.	Have you used any form of tobacco or nicotine products:			
	a) In the past 36 months?	❑	❑	
	b) In the past 12 months?	❑	❑	
6.	Have you ever used marijuana, hash, cocaine, heroin, or narcotics not prescribed to you by a physician?	❑	❑	
7.	Other than the above, within the past 5 years, have you had:			
	a) An examination or treatment by a doctor or medical practitioner?	❑	❑	
	b) Observation or treatment at a clinic, hospital, or other facility?	❑	❑	
	c) An EKG, stress test, x-ray, blood test, or any other diagnostic test?	❑	❑	
	d) A surgical operation or been advised to have a surgical operation?	❑	❑	
	e) A change of weight, anorexia nervosa, or bulimia?	❑	❑	
8.	a) If female, are you currently pregnant?	❑	❑	
	b) Have you ever had any complications with this or previous pregnancies?	❑	❑	
	c) Any disorders of the breast?	❑	❑	
9.	a) Do you have a family history of diabetes, cancer, stroke, kidney disease, high blood pressure, coronary artery disease, Huntington's chorea, alcoholism, drug abuse, or mental illness?	❑	❑	
	b) Have you ever received disability benefits from any source?	❑	❑	

I hereby declare that the answers and statements contained in this Part 2 application are full, complete, and true to the best of my knowledge and belief, and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 application shall be part of my application for insurance and will form part of the policy contract.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of insurance fraud.

Signed at: _____ Date: (M M / D D / Y Y Y Y)

City, State/Province

Witness: _____ Proposed Insured: _____

Signature of examiner

MEDICAL EXAMINERS REPORT

This section to be completed by all examiners.

All Proposed Insureds must be weighed and measured.

10. a) Height: _____

b) Weight: _____

Weight change in past year? _____

❑ Gain ❑ Loss

Cause? _____

11. Blood pressure:

Systolic: 1 _____ 2 _____ 3 _____

Diastolic: 1 _____ 2 _____ 3 _____

If blood pressure is over 140/90, take 3 readings at least 5 minutes apart.

12. Pulse: _____

Rhythm: _____

Irregularities? _____

If pulse is over 90, repeat in 5–10 minutes

13. Urinalysis:

Please indicate test results in the space provided. (This section to be completed on all examinations)

Albumin: _____

Glucose: _____

Blood: _____

Please forward urine sample to LABONE for microurinalysis.

14. Does the Proposed Insured appear older than the stated age?

❑ Yes ❑ No

15. Is there any evidence of alcohol, drug, or nicotine addiction?

❑ Yes ❑ No

This section to be completed by Physician only.

	YES	NO
16. Any evidence of past or present disease of:		
a) The brain or nervous system? (Test reflexes and coordination)	❑	❑
b) Head or neck? (Including ears, eyes, and mouth)	❑	❑
c) Endocrine system, breast, or glands?	❑	❑
d) Chest and lungs? (Examine on bare chest with expiratory cough)	❑	❑
e) Heart and blood vessels?	❑	❑
f) Abdomen? (Liver, spleen, abnormal masses, tenderness, surgical scars)	❑	❑
g) Genito-Urinary system? (Include prostate)	❑	❑
h) Musculoskeletal system? (Include spine/joint deformities)	❑	❑
i) Skin (Xanthomas, nevi, etc.), lymph nodes?	❑	❑
17. Is there:		
a) Evident arteriosclerosis?	❑	❑
b) Cardiac hypertrophy?	❑	❑
c) Cyanosis, dyspnea, or edema?	❑	❑
d) Cardiovascular impairment?	❑	❑
e) Any hernias or varicosities?	❑	❑
f) A heart murmur? (Complete heart chart)	❑	❑

18. Heart Chart

Murmur

Location: ❑ Apical ❑ Aortic ❑ Mitral ❑ Pulmonic

Timing: ❑ Systolic ❑ Diastolic ❑ Pre-systolic

Intensity: ❑ Soft ❑ Moderate ❑ Loud

Grade: I II III IV V VI

Is murmur constant? ❑ Yes ❑ No

Transmitted? ❑ Yes ❑ No

If transmitted, indicate where to: _____

Effect of exercise: ❑ Unchanged ❑ Decreased ❑ Increased ❑ Disappears

Your impression of murmur: _____

Mail exam to:

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19. Did you require an interpreter to question the Proposed Insured? ❑ Yes ❑ No

If "Yes," indicate interpreter's name and relationship to Proposed Insured: _____

20. How was client identified? (driver license, etc.) _____

Remarks (please comment fully on any abnormal findings and details of "Yes" answers)

I certify that I made this examination at:
- ❑ Proposed Insured's home
- ❑ Office
- ❑ Other _____

Signed at: _____ Date: _____ (MM/DD/YYYY) Time: _____

City, State

_____

Signature of examiner