PART TWO **INVESTORS HERITAGE LIFE INSURANCE COMPANY**

Proposed Insured _____ Date of Birth_____
(First Name Middle Initial Last Name) (Month Day 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?_____

	Yes	No
2. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis, 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, hepatitis, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Nephritis, kidney stone, any disease or disorder of the kidneys or bladder, any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy?	☐	☐
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 disorder of the blood?	☐	☐
3. Within the past 10 yrs, to the best of your knowledge have you had or: Been diagnosed by a member of the medical profession as having or been tested positive for, or been treated by a member of the medical profession for any of the following: Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Human Immunodeficiency Virus (HIV), or any other disease or disorder of the immune system?	☐	☐
4. Any mental or physical disorder not listed above?	☐	☐
5. Have you smoked cigarettes in any amount in the last 12 months?	☐	☐
6. In the past ten years, have you used:		
a. Alcoholic beverages to excess or intoxication?	☐	☐
b. Barbiturates, sedatives, or tranquilizers habitually?	☐	☐
c. L.S.D., marijuana, cocaine, or any amphetamine?	☐	☐
d. Heroin, morphine, or other narcotic drug?	☐	☐
7. In the past ten years, have you been treated for alcoholism or any drug habit?	☐	☐
8. Are you now under observation or taking treatment or medication?	☐	☐
9. Have you had any change in weight in the past year?	☐	☐
10. Other than above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, or 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?	☐	☐
11. Have you ever had military deferment, rejection or discharge because of an injury, sickness or disability?	☐	☐
12. Have you ever requested or received a pension, benefits, or payment because of injury, sickness or disability?	☐	☐
13. Family History: Have any of your parents, brothers, or sisters ever had heart disease, cancer, diabetes, or mental illness?	☐	☐

DETAILS of "Yes" answers.
IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, outcome, names, addresses and telephone numbers of all attending physicians and medical facilities.

14.

Family Information	Age if Living	Age at Death	Cause of Death	Number Living	Number Deceased
Father					
Mother					
Brothers and Sisters					

I hereby declare that all statements and answers given above are full, complete and true to the best of my knowledge and belief; and I agree that they, with the statements on my application, will be considered the basis of any insurance issued.

_____ _____
Signed at (City or Town, State) Date (Month Day Year)

_____ _____
Signature of Medical Examiner Signature of Person Examined

80301 (1-2005)

INVESTORS HERITAGE LIFE INSURANCE COMPANY

200 Capital Ave., PO Box 717, Frankfort, KY 40602-0717

PART THREE — **MEDICAL EXAMINER'S REPORT**

15a. Height (In Shoes)	Weight (Clothed)	Circumference (Males Only)		
		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, Umbilicus
ft. in.	lbs.	in.	in.	in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthly or older than stated? ☐ Yes ☐ No

16. Blood Pressure: (If blood pressure is above 140/90, record two additional readings after 10 minute rests.)

	Systolic	Diastolic (Phase V)
1st Reading		
2nd Reading		
3rd Reading		

17.

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

18. Heart: Is there any:

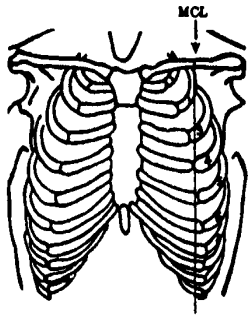
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

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

Location	1st MURMUR	2nd MURMUR
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:



Apex by X

Murmur area by O

Point of greatest intensity by ●

Transmission by ➡

- If a murmur is present, ask if there is any rheumatic or other type of infection;
- What do you think is the cause of this mumur?

19. On examination is there any abnormality of the following (Circle applicable items and give details.)

	Yes	No
(a) Eyes, nose, mouth, pharynx?..... (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?.....	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?.....	☐	☐
(d) Respiratory system?.....	☐	☐
(e) Abdomen (including scars)?.....	☐	☐
(f) Genitourinary system?.....	☐	☐
(g) Endocrine system (include thyroid and breasts)?.....	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?.....	☐	☐
20. Are there any hernias?.....	☐	☐
21. Are you aware of additional medical history?.....	☐	☐

(A confidential report may be sent to the Medical Director.)

22. Urinalysis: Specific Gravity_____ Albumin_____ Sugar _____

Details of "Yes" answers. (Identify item.)

Examiner: Print name:_____ Signature _____

Print name of person examined _____ Date of examination _____

Paramedical or medical firm name/address_____