KANSAS CITY LIFE INSURANCE COMPANY

Part 2-Medical Exam
Application for Life Insurance

Name in full. (Please print) | Date of birth | Place of birth

	YES	NO
1) Do you take prescription medicine?		
2) Have you used any form of nicotine/tobacco in the last 5 years? If yes, provide date of last use_____		
3) Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives?		
4) Have you sought advice, been treated or arrested for the use of alcohol?		
During the last 10 years have you been diagnosed, treated or been given advice by any member of the medical profession for:		
5) Depression, anxiety, bipolar disorder, epilepsy, seizures, TIA, stroke, paralysis or any other disorder of the brain or nervous system?		
6) High blood pressure, heart murmur, chest pain or pressure, heart attack, palpitations, aneurysm or any other cardiovascular disorder?		
7) Anemia, leukemia or any other blood disorder?		
8) Tumor or cancer?		
9) Diabetes, elevated blood sugar, sugar in urine, thyroid or glandular trouble or any other disorder of the endocrine system?		
10) Asthma, COPD, emphysema, sleep apnea, tuberculosis or any other disorder of the lungs or respiratory system?		
11) Ulcer, polyps, colitis, Crohn's disease or any other disorder of the digestive system?		
12) Cirrhosis, hepatitis or any other disorder of the liver?		
13) Protein or blood in urine or any other disorder of the bladder or kidneys?		
14) Arthritis, deformity, or any injury to or disorder of the bones, joints, muscles, back, neck or spine?		
15) Any disorder of the breasts, reproductive organs or prostate?		
16) Menstruation or pregnancy?		
17) Are you currently pregnant? If yes, provide due date:_____		
Have you ever been diagnosed or treated for:		
18) A sexually transmitted disease?		
19) Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC) or tested HIV positive?		
20) Have you received testing or consulted a physician for any reason other than what you have already stated?		
21) Any immediate family history of diabetes, cancer, heart or kidney disease, or stroke? If yes, indicate below		

*Provide details to all **Yes** answers. Identify question; specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

Relationship	Age if Living	Family History or Cause of Death	Age at Diagnosis	Age at Death
Father				
Mother				
Brothers and Sisters				

23) Names and addresses of personal or family physicians (If none, indicate none)

24) Date and reason last consulted | Clinic or VA Claim Number

AGREEMENTS AND SIGNATURES **I represent** that all the statements and answers to the above questions are **true and complete** to the best of my knowledge and belief. I agree that they **will** form a part of the contract of insurance applied for.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at_____ this_____ day of_____, 20_____

Witness: _____ _____

Examiner | Proposed Insured's Signature

MEDICAL EXAMINER'S REPORT
(NOT PART OF THE APPLICATION)

TO BE FILLED IN BY THE MEDICAL EXAMINER ONLY

1) Do you know the applicant?_____ How long?_____

2) As a patient?_____ Other?_____

3) Agency requesting this examination:_____

4) Height		Weight	Abdomen	Chest	
Ft.	In.	Present	At Waist	Insp.	Exp.
		lbs.	in.	in.	in.

Any weight change during the past 12 months?

Gain_____ lbs Loss_____ lbs.

5) Do you find evidence of past or present disease of: **Yes** **No**

a. Eyes, ears, nose or throat? ..... (State if hearing aid is used) ..... ☐ ☐
(Measure markedly impaired vision corrected and uncorrected)

b. Brain or nervous system (Test reflexes)? ..... ☐ ☐

c. Thyroid or lymph glands? ..... ☐ ☐

d. Chest, breasts or lungs? ..... ☐ ☐

e. Abdominal organs (Including hernia)? ..... ☐ ☐

f. Genito-urinary organs? ..... ☐ ☐

g. Skin or musculoskeletal system? ..... ☐ ☐

h. Vascular system (Varicose veins, ulcers, arteriosclerosis)? ..... ☐ ☐

6) Blood pressure *(If 140/90 or more report two additional readings)*

Systolic _____ _____ _____

Diastolic-5th Phase _____ _____ _____

7) Pulse — At Rest — *After Exercise — *3 minutes later

Pulse rate per minute _____ _____ _____

Irregularities per minute _____ _____ _____

*To be completed only if there is a heart murmur or arrhythmia – technique discretionary

8) Has applicant ever had any cardiac symptoms or sought medical advice for any disease of the cardiovascular system including hypertension? ☐ ☐

If so, please give details

9) a. Murmur? ☐ ☐

Location ☐Aortic ☐Pulmonic ☐Apical

Timing ☐Systolic ☐Presystolic ☐Diastolic

Intensity (Enter Grade 1 to 6)

Transmission ☐Axilia ☐Neck ☐Other

Effect of respiration ☐Increase ☐Decrease

Change of position ☐Increase ☐Decrease

Exercise ☐Increase ☐Decrease

Impression ☐Organic ☐Functional

b. **Hypertrophy of heart?** ..... ☐ ☐

(if yes, state degree)_____

10) Urinalysis

Albumin _____ Sugar_____

a. Are you satisfied specimen is authentic? ..... ☐ ☐

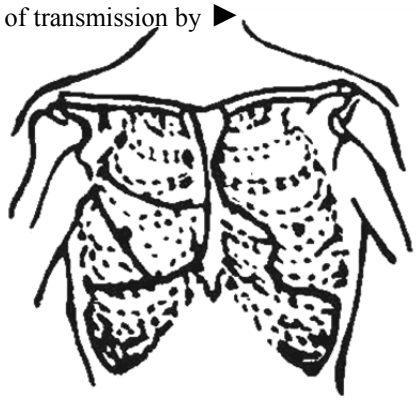
b. Are you forwarding specimen to Home Office? ..... ☐ ☐

REMARKS

Indicate where murmur heard by ■

Indicate point of greatest intensity by ●

Indicate direction of transmission by ▶



I certify that I have made this examination with the results recorded on this _____ day of _____, 20____

time_____ a.m. _____ p.m._____

If not a regular examiner please give

☐My Office Medical School_____ Date of Graduation_____

☐Applicant's residence

☐Applicant's place of business Amount of Insurance Applied for_____

_____
Examiner

A178-MD