APPLICATION FOR LIFE INSURANCE - PART 2 MEDICAL QUESTIONNAIRE

☐ Lincoln Benefit Life Company, P.O. Box 660191, Dallas, TX 75266-0191 FAX: 1-866-525-5433

☐ Allstate Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)
	☐☐☐☐☐☐☐☐

Policy Number (if assigned)

☐☐☐☐☐☐☐☐☐☐

1. Have you ever used tobacco or nicotine products? (If "yes," give details below) ☐ Yes ☐ No

☐ **Current** user of tobacco/nicotine products: ☐ Cigarettes, _____ packs per day Years smoked _____

☐ Other _____ Amount/day _____ Years used _____

☐ **Former** user of tobacco/nicotine products: Type(s) _____ When quit? (MM/YYYY) _____ Years used _____

☐ Cigarettes, _____ packs per day

☐ Other _____ Amount/day _____

2. Primary Physician Name _____ Phone Number _____

Address _____

Date (MM/DD/YYYY) and Reason Last Consulted _____

Diagnoses, test results **(excluding HIV test)**, treatment, and referrals _____

3. Do you have a family history of heart disorder, stroke or cancer beginning before age 65 in any natural parent or sibling? (If "yes," complete table below.) ☐ Yes ☐ No

Relationship to Proposed Insured	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

GIVE DETAILS OF ALL "YES" ANSWERS ON NEXT PAGE.

4. Have you ever been diagnosed with, or sought treatment or advice for:
   a. High blood pressure, heart attack, chest pain, murmur, abnormal heart valve, heart failure, abnormal heart rhythm, or other heart disorder? ☐ Yes ☐ No
   b. Stroke, mini-stroke (TIA), aneurysm, or other disorder of blood vessels? ☐ Yes ☐ No
   c. Cancer, tumor, polyp, or disorder of lymph nodes? ☐ Yes ☐ No
   d. Dependency on or addiction to alcohol or any drug? ☐ Yes ☐ No
5. Have you ever been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
6. In the past 10 years, have you been diagnosed with, or sought treatment or advice for:
   a. Epilepsy, seizures, fainting, paralysis, disorder of the brain or nervous system, mental or nervous disorder? ☐ Yes ☐ No
   b. Diabetes, elevated blood sugar, disorder of thyroid or other endocrine glands? ☐ Yes ☐ No
   c. Asthma, emphysema, shortness of breath, sleep apnea, sarcoidosis, tuberculosis, or other disorder of the lungs? ☐ Yes ☐ No
   d. Ulcers, colitis, enteritis, blood in the stool, hepatitis, cirrhosis, or other disorder of digestive tract, liver, or pancreas? ☐ Yes ☐ No
   e. Anemia, clotting disorder, or other disorder of blood, blood cells, or bone marrow? ☐ Yes ☐ No
   f. Disorder of kidneys, bladder, prostate, or reproductive organs; or blood in urine? ☐ Yes ☐ No
   g. Arthritis, lupus, or any disorder of muscles, bones, spine, or joints? ☐ Yes ☐ No
7. Other than previously disclosed, in the past 5 years, have you:
   a. Had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test **(excluding HIV test)**? ☐ Yes ☐ No
   b. Been advised to have a medical consultation, diagnostic test, or surgery that has not been done **(excluding HIV test)**? ☐ Yes ☐ No
8. Are you taking any prescription or over-the-counter medications, herbs, supplements, or alternative medications not previously disclosed? ☐ Yes ☐ No

COMPLETE QUESTIONS 9 A-E IF PROPOSED INSURED IS AGE 70 OR OLDER. GIVE DETAILS OF "YES" ANSWERS BELOW.

9. Within the past year, have you:

a. Used any medical devices to assist with mobility such as a wheelchair, cane, walker, leg braces, crutches, motorized cart, or chair lift? ☐ Yes ☐ No

b. Resided in a nursing home, residential care or assisted living facility? ☐ Yes ☐ No

c. Received home health care services or physical therapy? ☐ Yes ☐ No

d. Had any falls? ☐ Yes ☐ No

e. Needed assistance with bathing, eating, dressing, toileting, transferring into or out of bed or chair, taking medication, doing housework, preparing meals, or managing money? ☐ Yes ☐ No

Details of "yes" answers to questions 4 through 9:

Question Number	Medical Condition and How It Was Treated	Dates (MM/DD/YYYY)	Current Status	Name and Address of Physician/Facility

SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

Signed at (City, State)

Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Examiner as Witness

MEDICAL EXAMINER'S REPORT

1. Height	2. Weight	3. Waist at Umbilicus	4. Hips at Widest	5. Did you weigh? ☐ Yes ☐ No 6. Did you measure? ☐ Yes ☐ No
____ft. ____in.	_____lbs.	_____ in.	_____in.	

7. Has weight changed 10 lbs. or more in past year? (If "yes," give details) ☐ Yes ☐ No

8. Blood Pressure (Systolic/Diastolic)	If first reading above 140/90, take 2 additional readings.		9. Pulse Rate	Irregularities/min.
_____ / _____	_____ / _____	_____ / _____	_____	_____

10. Sent to Lab: ☐ Urine Specimen ☐ Blood Profile ☐ Other: _____

11. Is Proposed Insured currently menstruating? ☐ Yes ☐ No (Even if "yes," specimen should be collected.)

COMPLETE FOR PHYSICIAN EXAMS ONLY

12. Is/are there any:
- a. Heart enlargement? ☐ Yes ☐ No
- b. Dyspnea or rales? ☐ Yes ☐ No
- c. Carotid bruits? ☐ Yes ☐ No
- d. Cyanosis or edema? ☐ Yes ☐ No
- e. Other signs of CHF, CAD, or PVD? ☐ Yes ☐ No

13. Are there any heart murmurs? ☐ Yes ☐ No
- Murmur is: ☐ Constant ☐ Inconstant
- Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic
- Grade: ☐ Soft (1-2) ☐ Mod. (3-4) ☐ Loud (5-6)
- Location: _____
- Transmission: _____

14. Are there any abnormalities of:
- a. Eyes, ears, nose, mouth, pharynx? ☐ Yes ☐ No
- b. Skin (including scars), lymph nodes, blood vessels? ☐ Yes ☐ No
- c. Nervous system (including reflexes, gait, paralysis)? ☐ Yes ☐ No
- d. Respiratory system? ☐ Yes ☐ No
- e. Abdomen (including scars)? ☐ Yes ☐ No
- f. Genitourinary system (including prostate)? ☐ Yes ☐ No
- g. Endocrine system (including thyroid)? ☐ Yes ☐ No
- h. Musculoskeletal system (including spine, joints, amputations, deformities)? ☐ Yes ☐ No

15. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

16. Do you have any information or observations that have not already been noted or are inconsistent with stated history? ☐ Yes ☐ No

17. Do you have any relationship or business association with Proposed Insured? ☐ Yes ☐ No

EXPLANATIONS AND DETAILS OF ALL "YES" ANSWERS

How did you identify the Proposed Insured? _____

Examiner's Signature _____ Date (MM/DD/YYYY) _____

Examiner's Address _____ Examiner's Phone Number: _____

IF PROPOSED INSURED IS AGE 70 OR OLDER, COMPLETE SENIOR ASSESSMENT.