MTL Insurance Company

1200 Jorie Boulevard Oak Brook, Illinois 60523-2269

Part II Application for Life Insurance

Answers made to Medical Examiner

(Circle all applicable items and provide details for all "Yes" answers in Question 9.)

	Yes	No
1. Insured or Applicant a. Full Legal Name _____ b. Date of Birth _____		
2. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
3. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
4. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
5. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
6. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
7. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
8. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

9. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities. If more space is needed, attach on separate page.

Question	Details

10. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

11. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

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

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, a policy issued and delivered and the full first premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy shall take effect as of the date of issue shown therein; **Provided**, however, that if payment is made in exchange for a Conditional Receipt bearing the same date as Part I of this application, insurance shall take effect if the conditions stated in said receipt are satisfied;
3. That if the Company should issue a policy different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement", and the acceptance of any policy issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. A photocopy of this authorization shall be as valid as the original. This authorization expires two years after the date of the policy.

Signed at _____ Date _____

(City and State)

_____

Signature of Proposed Primary Insured (Age 15 and over)

_____

Signature of Parent/Legal Guardian (If minor under age 15)
(Include Title/Relationship)

_____

Signature of Witness (Medical Examiner)

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Voucher for Medical Examination (*Please Print*) ***Do Not Detach***

Name of person examined _____ Date examined _____ Fee _____

Name of Agent _____

Medical Examiner: Name _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Medical Examiner's Report (Both sides of this form are to be completed by the Medical Examiner)

1. a. Height (in shoes) _____ ft. _____ in. Scale Weight (clothed) _____ lbs.

Males Only: Chest (full inspiration) _____ in. Chest (forced expiration) _____ in. Abdomen, at Umbilicus _____ in.

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

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

2. Blood Pressure: (If systolic reading over 140 or diastolic over 90, or if Insured is markedly overweight, obtain three readings at intervals.)

	Initial	Additional Readings
Systolic		
Diastolic (5th phase)		

3. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

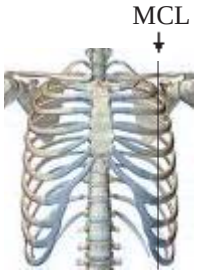
4. Heart: Is there any: Enlargement ☐ Yes ☐ No Murmur(s) ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No Edema ☐ Yes ☐ No

(Describe below - if more than one, describe separately.)

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

Indicate:
Apex by X
Murmur area by ☐
Point of greatest intensity by ○
Transmission by →

For comment and your impression:



5. Is there on examination any abnormality of the following: (Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, paralysis, tremors)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputation, deformities)?	☐	☐

6. Are there any hernias? ☐ Yes ☐ No

7. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.) ☐ Yes ☐ No

8. Have you known Insured previously? ☐ Yes ☐ No

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

10. Urinalysis: Specific Gravity _____ Albumin _____ Sugar _____ Is specimen being sent to Company lab? ☐ Yes ☐ No

Send urine specimen if Insured is applying for $100,000 or more of life insurance, or is (a) hypertensive or has other cardiovascular abnormalities, (b) markedly overweight, or (c) age 60 and over. Send 2 specimens (different days) if albumin, sugar, pus, blood or casts are present, or were found in past.

I have examined the Proposed Insured in private at:

☐ My Office ☐ Proposed Insured's Residence ☐ Proposed Insured's Place of Business ☐ Other _____

At _____ AM / PM _____ _____ M.D.

Time Date Medical Examiner Signature