MEDEXAM 01

☐ **NEW YORK LIFE INSURANCE COMPANY (NYLIC)** 51 Madison Avenue, New York, NY 10010
☐ **NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC)** (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
☐ **NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State)** 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Application Part II

First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for	Policy No./Tracking No.

1. In the last 5 years, has the Proposed Insured consulted his or her primary physician, or other member of the medical profession, or been seen at a medical facility?

☐ Yes ☐ No Name _____

Address _____ Phone number (_____) _____-_____

Date of last visit: _____ /_____ /_____ Reason for visit:_____

Treatment or medication provided: (Provide details, name and dosage) _____

2. List all medications prescribed in the last 2 years: (Include reason, dosage and frequency) _____

_____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)

a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse?	☐ Yes	☐ No
b. Elevated blood sugar or diabetes?	☐ Yes	☐ No
c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder?	☐ Yes	☐ No
d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma?	☐ Yes	☐ No
e. Multiple sclerosis; epilepsy, seizures; intellectual disability; memory loss or other neurological disorder?	☐ Yes	☐ No
f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder?	☐ Yes	☐ No
g. Stroke, transient ischemic attack (TIA) or other circulatory disorder?	☐ Yes	☐ No
h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA?	☐ Yes	☐ No
i. Colitis; blood in stool; intestinal polyps or other intestinal disorder?	☐ Yes	☐ No
j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder?	☐ Yes	☐ No
k. Any psychiatric or mental health condition (include counseling or hospitalization)?	☐ Yes	☐ No
l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use?	☐ Yes	☐ No

4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) ☐ Yes ☐ No

6. In the last two (2) years, other than as already stated, has the Proposed Insured:

a. Had any surgery or been recommended to have surgery?	☐ Yes	☐ No
b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy)	☐ Yes	☐ No
c. Been unable to work, unable to attend school or been disabled for 30 days or more?	☐ Yes	☐ No

7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship; medical condition; age at onset of illness; current age, if alive, or age at death. If cancer indicated, provide type or location.) ☐ Yes ☐ No

8. a. In the last 12 months, has the Proposed Insured had a change in weight greater than 10 pounds? ☐ Yes ☐ No
b. If "Yes", please provide how many pounds lost _____ or how many pounds gained _____ and check off all that apply:
☐ Diet ☐ Exercise ☐ Surgery ☐ Pregnancy ☐ Unknown

9. Complete the following questions if the Proposed Insured is actual age 70 or over:

a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home?	☐ Yes	☐ No
b. Does the Proposed Insured live in a facility that provides him or her with personal care?	☐ Yes	☐ No
c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation?	☐ Yes	☐ No
d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply)	☐ Yes	☐ No

Give full details on Page 2 for all questions answered "Yes" above.

First Name Middle Name Last Name

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" on Page 1. If more space is needed, please use another form.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info

By SIGNING BELOW, I/WE DECLARE THAT, to the best of my/our knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true. I/We also understand that the Insurer will rely upon the answers in this Part II in determining if (and on what basis) life insurance may be issued on the life of the person examined, and that this Part II will be attached to and made part of any such life insurance policy.

Dated at_____ on _____ /_____ /_____ _____
(City, State) (mm/dd/yyyy) Signature of person examined

_____ Witnessed by_____
Signature of Parent or Guardian, if person examined is under age 14 years and 6 months; 18 years in PA

MEDEXAM 03

Examiner's Report – Not Part of the Application

Agent Name _____
G.O. Code _____ *Agent Code* _____

First Name Middle Name Last Name

10. Height _____ft. _____in. Weight _____lbs.

11. **Blood Pressure.** Take a second and third reading at the end of the examination; one from each arm. Report all observations. (Do not complete if examinee is under age 12.)

	1st reading	2nd reading	3rd reading
Systolic	_____ mm.	_____ mm.	_____ mm.
Diastolic	_____ mm.	_____ mm.	_____ mm.

12. **Pulse.** (Do not report if examinee is under age 12.)

Pulse rate at rest _____ Per/Min.

Any pulse irregularity? ☐ Yes ☐ No
(If "Yes", obtain EKG and provide details below)

13. Did you measure the height of the examinee? ☐ Yes ☐ No
If "No", provide details below.

14. Did you weigh the examinee? ☐ Yes ☐ No
If "No", provide details below.

15. Did you observe any indication of physical or mental impairment not indicated on the medical form? (If "Yes", provide details below) ☐ Yes ☐ No

16. Are you related to the person examined or has the person ever consulted you for any reason other than an insurance examination? (If "Yes", provide details below) ☐ Yes ☐ No

17. Did the person examined communicate in English well enough to understand and answer the questions on the medical form? ☐ Yes ☐ No
If "No", who acted as interpreter? ☐ Examiner ☐ Agent ☐ Other (Name and relationship to insured. The owner or beneficiary of this insurance may not act as interpreter. A disinterested party must be used.) _____

All specimens are to be sent to lab for analysis.

COMPLETE THIS SECTION *ONLY* FOR A FULL MEDICAL EXAM.

18. **Cardiovascular Examination.**

a. Is there any evidence of cardiovascular disease excluding murmur? (If "Yes", provide details below) ☐ Yes ☐ No

b. Is a murmur present? (If "Yes", complete this section.) ☐ Yes ☐ No

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic

Location: ☐ Apex ☐ Aortic ☐ Pulmonic ☐ Other _____

Transmission: ☐ Axilla ☐ Neck ☐ Precordium ☐ None ☐ Other _____

Intensity: ☐ Soft (Gr. 1-2) ☐ Moderate (Gr. 3-4) ☐ Loud (Gr. 5-6)

Impression: _____

19. **Comments or Details to answers above:**

Ques. No.	Comments or Details
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I CERTIFY that I have carefully examined the person named above and not in the presence of any other person except as stated in the comments section, that I have asked each question exactly as set forth on Page 1 and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this page and Page 1 and 2, and believe them to be correctly recorded, complete and true.

Please print your name _____ Signature _____

Name of examining company _____ Date _____ /_____ /_____

Please stamp / provide Social Security No. or Tax ID No. and address. SS # or TIN # _____

Address: Street _____ City _____

State _____ Zip _____ Country _____

TO THE EXAMINER: Any erasures or alterations in this report should be initialed by you. A copy of "answers to the Examiner" (Page 1 and 2) is included in any policy issued; the "examiner's report" (this page) is not included in the policy. If you have any information included above or not shown on this form which you believe should be seen only by Underwriting personnel, please send this report and any confidential information directly to Life Medical Underwriting, New York Life, 51 Madison Avenue, New York, NY 10010.