The Northwestern Mutual Life Insurance Company
720 East Wisconsin Avenue
Milwaukee, Wisconsin 53202

Northwestern Long Term Care Insurance Company
P.O. Box 3124
Milwaukee, WI 53201-3124

PHYSICAL MEASUREMENTS EXAMINATION INSTRUCTIONS

Please read carefully before beginning the Examination.

Instructions	Complete the Physical Measurements Examination (form 90-4E) in its entirety. The examiner must sign the page, and the city, state, and date of completion must be filled in.
Personal, Business or Professional Relationships	This examination should not be performed if you: • are related to or have a personal, professional or business relationship with the person to be examined or the Northwestern Mutual Financial Representative (Agent), or • have any business association with a Northwestern Mutual Network Office.
Identification	If the Insured cannot or will not provide proper picture or other verification of his/her identity, e.g., driver's license, please do not perform the examination. Contact the Financial Representative.
Complete All Exams in Private	Examinations need to be completed in private. No one other than the Insured may be present during this examination. If the Insured requests a gender specific examiner, nurse or medical assistant, one should be provided.
Complete All Exams in Entirety	Legibly record all answers in your own handwriting using a pen (blue or black ink). If the Insured refuses any part of the measurements, indicate this on the examination form. Do not write "deferred" for any response. If any part of the examination cannot be completed adequately, the reason should be indicated on the examination form. Report any other health information obtained during the examination process even though such information may not have been specifically required.
Alterations	Your alterations on the Physical Measurements Examination (form 90-4E) should be initialed by you.
No Financial Representative Influence	The Financial Representative may not proof, edit, rewrite, influence or discuss any part of the examination with the Insured, parent/legal guardian, or you at any time. Such activity should be reported to the Manager of New Business Requirements at the Northwestern Mutual home office at (414) 271-1444.
Property of The Northwestern Mutual Home Office	This Physical Measurements Examination, and all information collected in connection with the completion thereof, are the property of the Northwestern Mutual home office and may not be (1) used by you for any purpose other than the requested review, or (2) disclosed to any third party without prior written consent from the Director – Underwriting Requirements, Northwestern Mutual, P.O. Box 2950, Milwaukee, WI 53201-2950. All completed examinations must be forwarded to the Northwestern Mutual Financial Representative, Network Office or home office. If incomplete, send directly to: Director – Underwriting Requirements. Please notify Northwestern Mutual promptly in the event of any theft, loss, or misplacement of confidential information, in whatever form.

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PHYSICAL MEASUREMENTS EXAMINATION

POLICY NUMBER

☐ LIFE
☐ DI
☐ LTC

INSURED NAME (First, Middle Initial, Last) PRINT NAME	INSURED PHONE NUMBER ( )	☐ FEMALE ☐ MALE

DRIVER'S LICENSE NUMBER	DRIVER'S LICENSE STATE	WAS A PICTURE ID SHOWN FOR VERIFICATION? ☐ YES ☐ NO

DATE OF BIRTH *(MM/DD/YYYY)*	SOCIAL SECURITY NUMBER *ONLY RECORDS LAST 4 DIGITS* XXX-XX-

1. A. HEIGHT *(WITHOUT SHOES) (PHYSICALLY MEASURE)* _____ FT _____ IN	B. WEIGHT *(CLOTHED, WITHOUT SHOES) (PHYSICALLY WEIGH)* _____ LBS

C. HAVE YOU LOST MORE THAN 10 POUNDS IN THE LAST 6 MONTHS? ..... ☐ YES ☐ NO
IF "YES," INDICATE THE NUMBER OF POUNDS LOST _____. PROVIDE REASON FOR WEIGHT LOSS:_____

2. BLOOD PRESSURE *(NOT REQUIRED UNDER AGE 10)* Take three readings at rest while seated. SYSTOLIC/DIASTOLIC _____ / _____ _____ / _____ _____ / _____	CUFF SIZE ☐ Regular ☐ Large ☐ Other _____

3. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE INSURED?
☐ YES ☐ NO IF YES, EXPLAIN: _____

4. ARE YOU RELEATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUINESS RELATIONSHIP WITH THE FINALCIAL REPRESENTATIVE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

5. ARE YOU CONNECTED WITH A NORTHWESTERN MUTUAL NETWORK OFFICE THROUGH EMPLOYMENT, FAMILY RELATIONSHIP OR OTHERWISE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

6. PLACE OF EXAMINATION
☐ INSURED'S HOME ☐ INSURED'S PLACE OF BUSINESS
☐ PARAMEDICAL COMPANY BRANCH OFFICE ☐ OTHER (SPECIFY LOCATION) _____

7. DATE OF EXAMINATION *(MM/DD/YYYY)*	TIME OF EXAMINATION _____ ☐ AM ☐ PM

8. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE

I certify that the above is a record of the measurements I completed on the Insured and that I completely and accurately recorded the information and answers. I certify that I have complied with all the instructions on the Physical Measurements Examination Instructions page for this examination.

_____
SIGNATURE OF PARAMEDICAL EXAMINER

PARAMEDICAL EXAMINER NAME *(PRINT OR STAMP)*	PHONE NUMBER ( )

NAME OF PARAMEDICAL COMPANY *(SELECT ONE)*
☐ APPS (AMERICAN PARA PROFESSIONAL SYSTEMS) ☐ EMSI (EXAMINATION MANAGEMENT SERVICES, INC.) ☐ EXAMONE ☐ PORTAMEDIC

OFFICE ADDRESS	CITY	STATE	ZIP CODE