❒ The Ohio National Life Insurance Company
❒ Ohio National Life Assurance Corporation/*Cincinnati*

P.O. Box 237
Cincinnati, Ohio 45201

Please print all answers.

Part 2 Application

1. Print Name of Proposed Insured

_____

2. When were you last examined for insurance and for what company?

_____

3. a. Name and address of your personal physician? (If none, say "none.")

_____

_____

_____

b. Date and reason last consulted

_____

c. What treatment was given or medication prescribed?

4. a. Proposed Insured's Family History

		Living		Dead
	Age	State of Health	Age	Cause of Death
Father Mother				
Brothers				
Sisters				

b. Did either parent, brother or sister ever have cancer, diabetes, or heart disease? (If "yes," give details.) ❒ Yes ❒ No

Check Applicable Items

	Yes	No
5. Have you ever:		
a) received disability benefits, compensation or a pension?	❒	❒
b) had high blood pressure or treatment thereof?	❒	❒
c) had pain or other discomfort in the chest?	❒	❒
d) had kidney stones, sugar, albumin or blood in the urine?	❒	❒
e) once or more than once used cocaine, marijuana, barbiturates, narcotics, excitants, anabolic steroids, or hallucinogens except as medication prescribed by a physician?	❒	❒
f) been treated or advised to seek treatment for drug abuse or alcoholism?	❒	❒
g) been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immune Deficiency Syndrome)?	❒	❒
6. Have you ever had any of the following:		
a) heart murmur, palpitation, abnormal pulse or any other heart or circulatory trouble including varicose veins?	❒	❒
b) nervous or mental trouble, convulsions, epilepsy, paralysis, dizzy or fainting spells, sick or severe headaches, psychological or psychiatric illness?	❒	❒
c) asthma, bronchitis, emphysema, shortness of breath, pleurisy, tuberculosis or any other disorder of lungs?	❒	❒
d) ulcers or any disorder of the stomach, liver, gallbladder, pancreas, intestines, appendix, or rectum including hemorrhoids and hernia?	❒	❒
e) disorder of the kidneys, bladder, prostate or genito-urinary organs?	❒	❒
f) cancer, tumor, cyst, syphilis, goiter or diabetes?	❒	❒
g) gout, disorder of bone, joint, back, spine, arthritis, or any deformity?	❒	❒
h) allergy or any disorder of the spleen or lymph glands?	❒	❒
i) disorder of the skin, eyes, ears, nose, sinuses, throat or larynx?	❒	❒
j) disorder of breasts or pelvic organs?	❒	❒
7. Have you within the past 5 years, other than noted above,		
a) had a check-up, consultation, illness, injury, or surgery?	❒	❒
b) been a patient in a hospital, clinic or sanitarium?	❒	❒
c) had an EKG, X-ray or other diagnostic tests?	❒	❒
d) been advised to have any diagnostic test, hospitalization or surgery, which was not completed?	❒	❒
8. Have you within the past 12 months,		
a) smoked any cigarettes?	❒	❒
b) used other forms of tobacco such as cigars, pipe or snuff?	❒	❒
9. Are you now under observation or taking treatment?	❒	❒
10. Has your weight changed more than 10 pounds in the past year? *If "yes," indicate the gain or loss, cause, and how long present weight maintained.*	❒	❒
11. Are you pregnant?	❒	❒

Details of "Yes" answers. Identify question number (include diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities.) Attach Form 6501 if an additional sheet of paper is necessary.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

A copy of this application will be attached to and made part of the policy issued.

Dated _____ at _____
City State

_____
Signature of Proposed Insured

Witnessed by _____
(Medical Examiner)

_____
Signature of Parent or Guardian if Proposed Insured is a minor

Authorization

To any physician, practitioner, hospital, clinic or other medical or medically-related facility, health care provider, insurance company or reinsurance company, insurance support organization, the Veterans Administration, MIB, Inc. (Medical Information Bureau), a consumer reporting agency, or employer:
In order to enable Ohio National Life to act upon my application for insurance or to decide if I quality for benefits or coverage, **I authorize** you to give Ohio National Life (or to its legal representatives) any and all information, records or knowledge which you have about my physical or mental condition. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, and includes information about drugs, alcoholism or mental illness. You may also give Ohio National Life any financial, employment or personal information requested for insurance purposes.

Ohio National Life may release information to reinsurance companies, to MIB, Inc., or to others who perform business or legal services related to my application or the policy. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

- This authorization is good, as needed, for 24 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I understand that I have a right to receive a copy of this authorization.

_____
Signature of Proposed Insured or Claimant

_____
Date

Examiners Report

1a. Proposed Insured's name

1b. Date of birth

2. How did you identify the person to be examined?
❒ Drivers License ❒ Other Picture I.D. (Describe): _____ Are you related? ❒ Yes ❒ No

3.a. Height (in shoes) ____ ft. ____ in.

3b. Weight (in clothes) ____ lbs.

3c. Measurements
CHEST EXPANDED ____ in.
CHEST CONTRACTED ____ in.
WAIST ____ in.

3d. Did you:
measure? ❒ Yes ❒ No
weigh? ❒ Yes ❒ No

3e. Is appearance unhealthy or older than stated age?
❒ Yes ❒ No

4. Blood Pressure

	SYSTOLIC	DIASTOLIC
1ST READING		
2ND READING		
3RD READING		

If systolic reading is over 140 or diastolic over 90, submit three observations taken several minutes apart.

5. Pulse Rate

❒ Regular
❒ Irregular

6. Are there any abnormalities of the:	Yes	No
a. eyes, ears, nose, mouth, throat?	❒	❒
b. skin (include scars), lymph nodes, varicose veins or peripheral arteries, edema?	❒	❒
c. nervous system (include reflexes, gait, paralysis)?	❒	❒
d. heart, cardiovascular system?	❒	❒
e. respiratory system?	❒	❒
f. abdomen (include hernias and scars)?	❒	❒
g. genito-urinary system?	❒	❒
h. endocrine system (include thyroid and breasts)?	❒	❒
i. musculoskeletal system (include spine, joints, amputations, deformities)?	❒	❒

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

Details of "yes" answers in questions 6 and 7.

Examination was made at:
❒ residence ❒ business ❒ my office

TIME ___ :___ ___ o'clock ❒ a.m. ❒ p.m.

DATE

MEDICAL EXAMINER _____

ADDRESS _____