SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
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Application for Individual Life Insurance—Part 2 – Medical

QUESTIONS TO BE ANSWERED BY PROPOSED INSURED NAMED IN APPLICATION PART 1 (referred to in this Part 2 as "YOU").

(Please print or type all information in black ink.)

Name of Proposed Insured _____ Date of Birth _____

1. FAMILY HISTORY
Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having cancer, coronary artery disease, stroke, kidney disease or diabetes? ❑ Yes ❑ No If "No", proceed to question 2.

		Age if Living	Age at Death	Give details of cause of death or diagnosis and age at diagnosis.
A.	Mother			
B.	Father			
C.	Sister(s)			
D.	Brother(s)			

2. Your Height _____ Weight _____
Describe any weight change in past 12 months ❑ Gained ❑ Lost _____ lbs.

3. A. Name of your personal physician(s) (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
Specialty, if any _____
B. Date of last visit (within 5 years) _____
C. Diagnosis or outcome of 3. B. _____
D. What treatment was given or medication(s) prescribed for 3. C.?_____
_____If none, check ❑
E. List all medications used in the past year_____
_____If none, check ❑
F. Physician who can provide us with the most complete and up-to-date medical records. (If different from above.)
Name of Physician (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____

If you answer "Yes" to any of the following questions, circle applicable medical condition and provide details in question 10.

4. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
A. Coronary artery disease, chest pain, angina, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, fainting spells or other disorder of the heart? ❑ Yes ❑ No
B. Diabetes or any disorder of the thyroid, pituitary, adrenals, pancreas or other endocrine disorder? ❑ Yes ❑ No
C. Skin disease, growth, rash, tumor or cyst? ❑ Yes ❑ No
D. Kidney stone, or any disease of the kidneys, bladder, prostate, testicles, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system? ❑ Yes ❑ No
E. Convulsions, seizures, epilepsy, stroke, TIA (transient ischemic attack (mini-stroke)), Alzheimer's Disease, dementia, Parkinson's Disease, Multiple Sclerosis, ALS (amyotrophic lateral sclerosis), neuropathy or recurrent dizziness or headaches? ❑ Yes ❑ No
F. Shortness of breath, sleep apnea, asthma, cystic fibrosis, emphysema, chronic lung disease, tuberculosis, asbestosis, coughing up or spitting up of blood, pneumonia, bronchitis, pleurisy, hoarseness or cough lasting more than 6 weeks, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No

G. Jaundice, intestinal bleeding, persistent diarrhea, ulcer, esophagitis, Barrett's esophagus, gastritis, duodenitis, pancreatitis, colitis, diverticulitis, hepatitis, Crohn's Disease, Ulcerative Colitis or other disorder of the esophagus, stomach, liver, gallbladder, pancreas, intestines or rectum? ❑ Yes ❑ No

H. Any disorder or disease of eyes, ears, nose or throat? ❑ Yes ❑ No

I. Phlebitis, blood clot, thrombosis, embolus, aneurysm, arterial narrowing, vasculitis or gangrene? ❑ Yes ❑ No

J. Amputation, deformity, osteoarthritis, lupus, rheumatoid arthritis, scleroderma, or other injury or disorder of the back, neck, muscles bones, joints or spine? ❑ Yes ❑ No

K. Mental or emotional disorder, depression, anxiety disorder, ADD (attention deficit disorder), ADHD (attention deficit / hyperactivity disorder), schizophrenia, bipolar disorder or other psychosis, psychiatric or neurological disorder? ❑ Yes ❑ No

L. Cancer, tumor, mass or growth of any kind arising in or spreading to any organ or tissue of the body including the blood, bone marrow or lymph glands? ❑ Yes ❑ No

M. Any infection, inflammation, anemia, polycythemia, immune deficiency (other than HIV) or other inherited or acquired condition not mentioned above? ❑ Yes ❑ No

N. Any surgery or biopsy? Any catheterization of the heart or arteries? ❑ Yes ❑ No

O. Within the past 12 months have you been under observation by a member of the medical profession or taking medication or treatment for any illness, condition or injury not mentioned above? ❑ Yes ❑ No

5. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or HIV (Human Immunodeficiency Virus)? ❑ Yes ❑ No

6. Other than as disclosed above, have you within the past 5 years:

A. Been a patient in a hospital, clinic, or other medical or treatment facility? ❑ Yes ❑ No

B. Been advised by a member of the medical profession to have any diagnostic test or procedure, hospitalization, treatment, or surgery, whether or not completed (other than HIV)? ❑ Yes ❑ No

7. Have you ever used any narcotic, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? ❑ Yes ❑ No

If "Yes", provide name(s), form(s), quantity, frequency and duration of use, and date last used, for each drug and/or substance used. _____

_____

8. Have you ever:

A. Been advised to reduce or discontinue the use of alcohol? ❑ Yes ❑ No

B. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use? ❑ Yes ❑ No

C. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug-related problems? ❑ Yes ❑ No

9. Are you now pregnant? ❑ Yes ❑ No

If "Yes", how many months? _____

10. Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Proposed Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment including psychiatric conditions, drug or alcohol abuse, and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for two and one-half years from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

I declare and represent that the statements and answers provided in this Application for Individual Life Insurance—Part 2 - Medical have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance.

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.

_____	_____	_____
Date	Signature of Medical Examiner	Signature of Proposed Insured