TIAA CREF
Financial Services

TIAA-CREF LIFE INSURANCE COMPANY
New Business Administration Office: P.O. Box 1258, Charlotte, NC 28201-1258
Home Office: 730 Third Avenue, New York, NY 10017-3206

LIFE INSURANCE ENROLLMENT FORM – PART II
MEDICAL REPORT

Please Print in Black or Blue Ink

INSTRUCTIONS TO EXAMINER

This examination, once begun, is the property of the TIAA-CREF Life Insurance Company and must not be destroyed, suppressed, or given to the Proposed Insured. Please weigh the applicant and answer all questions below. All positive findings should be explained in detail in the "Remarks" section.

Section A: Proposed Insured

Full Legal Name (Title, First, Middle, Last, Suffix)		
Residential Address		Apt. No.
City	State	Zip Code
Gender ☐ M ☐ F	Date of Birth	Social Security #

Section B: Medical History

1. PRIMARY CARE PHYSICIAN		
Name	Telephone No. - -	
Address		
City	State	Zip Code
a. Date of last consult with this physician?		
b. Reason for last consult with this physician?		
c. Test(s) performed and treatment received, excluding HIV antibody, sero-positivity, T-cell count, HIV infection, AIDS or ARC tests?		

If the answer is "Yes," to any of the questions listed below, provide full details in the "Remarks" section.

2. IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED OR TREATED FOR:		
a. High blood pressure, elevated cholesterol, chest pain, angina, heart attack, heart disease, heart murmur, palpitations, stroke, peripheral vascular disease, cerebrovascular disease, or any other disorder of the heart or circulatory system?	☐ Yes	☐ No
b. Diabetes, glucose intolerance, thyroid or pituitary disorder or any other endocrine or glandular disorder?	☐ Yes	☐ No
c. Tumors, malignant or benign, cancer, melanoma or any other disease of the skin, lymphoma, enlarged lymph nodes, leukemia or any other malignant disorder.	☐ Yes	☐ No
d. Asthma, shortness of breath, COPD, emphysema, pneumonia, bronchitis, tuberculosis, or any other disorder of the respiratory system?	☐ Yes	☐ No
e. Depression, anxiety, panic attacks, ADD/ADHD, emotional disorder, or any other psychiatric disorder or disturbance?	☐ Yes	☐ No
f. Seizure disorder, fainting, dizziness, multiple sclerosis, paralysis, or any other neurological disorder of the brain or nervous system?	☐ Yes	☐ No

Section B: Medical History (Continued)

If the answer is "Yes," to any of the questions listed below, provide full details in the "Remarks" section.

2. IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED OR TREATED FOR (Continued):		
g. Hepatitis, cirrhosis, or any other liver disorder?	☐ Yes	☐ No
h. Ulcerative colitis, Crohn's disease, gastrointestinal bleeding, gastric or peptic ulcer, acid reflux disease, Barrett's esophagus, disorder of the stomach, pancreas, gall bladder, or any other intestinal disorder?	☐ Yes	☐ No
i. Albumin, protein, blood or sugar in the urine or any disorder of the kidney, bladder, breasts, ovaries, prostate or other reproductive organs?	☐ Yes	☐ No
j. Any sexually transmitted diseases?	☐ Yes	☐ No
k. Gout, arthritis, connective tissue disease, immune system disorder or any other disease of the joints, muscles, nerves or bones?	☐ Yes	☐ No
l. Anemia, clotting or platelet disorder, chronic infections, or any other disorder of the blood?	☐ Yes	☐ No
m. Any disorder of the eyes, ears, nose, or throat?	☐ Yes	☐ No
3. Are you currently pregnant?	☐ Yes	☐ No
If "Yes," what is the expected date of delivery?		
4. Has your weight changed by more than 10 lbs during the past 12 months?	☐ Yes	☐ No
If "Yes," please provide reason for the weight change; if you gained or lost weight; and how much. lbs.	☐ Gain	☐ Loss
5. Has the Proposed Insured ever tested positive for antibodies to the AIDS (Acquired Immune Deficiency Syndrome) Human T-Cell Lymphtropic Human Immunodeficiency Virus (HIV)?	☐ Yes	☐ No
6. Have you ever been advised by a licensed medical professional to reduce or discontinue the use of alcohol or drugs?	☐ Yes	☐ No
7. Other than as noted above, have you ever been counseled or treated because of alcohol, controlled substance or drug use?	☐ Yes	☐ No
8. Have you ever used narcotics, amphetamines, barbiturates, heroin, cocaine, marijuana, or other habit-forming drugs, except as prescribed by a licensed medical professional?	☐ Yes	☐ No
9. OTHER THAN AS PREVIOUSLY DESCRIBED, HAVE YOU EVER:		
a. Consulted with a physician, healthcare provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test (excluding HIV antibody, sero-positivity, T-cell count, HIV infection, AIDS or ARC tests), or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed?	☐ Yes	☐ No
b. Been an inpatient or outpatient in a hospital, clinic, medical or mental health facility?	☐ Yes	☐ No
c. Had surgery or biopsy, received treatment by a healthcare provider, or received treatment at a medical facility?	☐ Yes	☐ No
d. Had any electrocardiograms, x-rays, blood studies, scans, or other diagnostic tests, excluding HIV antibody, sero-positivity, T-cell count, HIV infection, AIDS or ARC??	☐ Yes	☐ No
10. Are you presently taking any medication(s), including nonprescription/over-the-counter medication or supplements? If "Yes," list all medications and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over-the-counter drugs, aspirin and herbal supplements in the chart on the next page.	☐ Yes	☐ No

REMARKS (Complete this section if you answered "Yes," to any of the questions above.) If more space is needed, an additional blank sheet may be attached. Any Proposed Insured(s) or Owner(s) should sign and date additional pages.

Question No. and Letter	Name and Address of Health Professional	Date/Duration of Illness	Diagnosis/Treatment/Medication

Section C: Family History (Please provide details in the chart below.)

1. Has a parent or sibling ever had: heart disease, coronary artery disease, vascular disease, stroke, cerebrovascular disease, diabetes, cancer, or kidney disease? If "Yes," please provide details in the table below. ☐ Yes ☐ No

Relationship to Proposed Insured	Age of Onset	Age if Living	Age at Death	State of Health (Specific Conditions) or Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				

Signature Section

Agreement

I, the Proposed Insured, have read the above answers and statements and they: (a) are true and complete to the best of my knowledge and belief and (b) were correctly recorded before I signed this LIFE INSURANCE ENROLLMENT FORM - PART II. These answers, together with those provided in Part I of the Enrollment Form and any additional supplements to this enrollment form constitute the entire Enrollment Form. I understand TIAA-CREF Life Insurance Company will rely upon the information provided in the Enrollment Form to determine whether it will issue the life insurance certificate applied for in this Enrollment Form.

General Fraud Warning

For Residents of AL, AK, AR, CA, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MI, MN, MO, MS, MT, NE, NH, NM, NV, NC, ND, OH, OK, RI, SC, SD, TN, TX, UT, VT, WV, WI, WY. and those residing outside the US:

Any person who, knowingly and with intent to defraud any insurance company or other person, files an enrollment form for insurance or a statement of claim for insurance benefits containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

For Residents of AZ:

Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an enrollment form for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

Signature Section (Continued)

For Residents of CO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Residents of DC:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of FL:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an enrollment form containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of MD:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of ME:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

For Residents of NJ:

To the best of my knowledge and belief, all of the above statements and answers are true and complete. Any person who includes any false or misleading information on an enrollment form for an insurance certificate is subject to criminal and civil penalties.

For Residents of OR:

Any person who, knowingly and with intent to defraud any insurance company or other person, files an enrollment form for insurance or a statement of claim for insurance benefits containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

For Residents of PA:

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Residents of VA:

Any person who, knowingly and with intent to defraud any insurance company, files an enrollment form for insurance or a statement of claim for insurance benefits containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

For Residents of WA:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X_____	_____	_____
Signature of Proposed Insured	Signed at (City, State)	Date
X_____	_____	_____
Signature of Witness	Signed at (City, State)	Date

Section D (TO BE COMPLETED BY PARAMEDIC OR PHYSICIAN)

The questions which appear below are intended only as a basis for the examination. TIAA-CREF Life Insurance Company relies on its examiners to observe and report all information bearing on the acceptance of a Proposed Insured, even though not specifically requested, on a separate sheet and mail it directly to TIAA-CREF Life Insurance Company.

1. a. Height (in shoes)	ft.	in.	b. Weight (clothed)	lbs.
c. Did you weigh the patient?	☐ Yes	☐ No		
If "No," please explain.				

2. Blood Pressure	Initial Reading	2nd Reading	3rd Reading
	Systolic	Systolic	Systolic
	Diastolic	Diastolic	Diastolic

3. Pulse at Rest	
Describe any irregularities	Number of irregularities per minute

4. Urinalysis		
Specific Gravity?	Albumin?	Sugar?

5. Are blood and urine specimens being collected and mailed to the lab?	☐ Yes	☐ No
Indicate Name of Lab		
6. Does the Proposed Insured currently use or has he or she ever used tobacco or nicotine-based products in any form? If "Yes," provide details in the "Additional Remarks" section below.	☐ Yes	☐ No
7. If your examination revealed any condition requiring further investigation or immediate treatment, have you advised the Proposed Insured? If "Yes," provide details in the "Additional Remarks" section below.	☐ Yes	☐ No
8. a. Are you aware of any additional medical history or findings not referenced in the above questions: (signs, symptoms, or laboratory tests/results)? If "Yes," provide details in the "Additional Remarks" section below.	☐ Yes	☐ No
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age?	☐ Yes	☐ No

ADDITIONAL REMARKS

Section D (TO BE COMPLETED BY PARAMEDIC OR PHYSICIAN) (Continued)

9.	a. How long have you known the Proposed Insured?		
	b. Are you related to the Proposed Insured or to the agent?	☐ Yes	☐ No
	c. Are you the Proposed Insured's Primary Care Physician?	☐ Yes	☐ No
	d. Was the examination conducted in a language other than English?	☐ Yes	☐ No
	If "Yes," indicate language used and provide name, address and relation to Proposed Insured of person acting as interpreter.		
	Language Used		
	Name of Interpreter / Relation to Proposed Insured		
	Address		
	City / State / Zip Code		
10.	How did you identify the Proposed Insured? ☐ Driver License No. ☐ Passport ☐ Visa ☐ Other_____ Photo identification required.		

Section E (COMPLETE THIS SECTION ONLY IF THE EXAMINATION IS DONE BY A PHYSICIAN)

1.	After physical examination and inquiry, did you find any abnormality of the following:		
	a. Skin (incl. Scars), thyroid, lymph nodes, veins, peripheral arteries?	☐ Yes	☐ No
	b. Brain, nervous system (include reflexes, gait, coordination, paralysis)?	☐ Yes	☐ No
	c. Respiratory system?	☐ Yes	☐ No
	d. Stomach, abdominal organs?	☐ Yes	☐ No
	e. Enlarged liver?	☐ Yes	☐ No
	f. Genitourinary system?	☐ Yes	☐ No
	g. Heart or blood vessels?	☐ Yes	☐ No
2.	Complete question # 2 if you answered "Yes," to any part of question # 1, if there is a history of rheumatic fever, heart murmur, or if you found any abnormality in heart size, rhythm, or sounds.		
	a. Is there evidence of cardiac enlargement or abnormal location of the apical impulse?	☐ Yes	☐ No
	b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?	☐ Yes	☐ No
	c. Are there gallops (S3 or S4)?	☐ Yes	☐ No
	d. Is/are there ejection sound(s) or systolic click(s)?	☐ Yes	☐ No
	e. Is/are there murmur(s) present?	☐ Yes	☐ No
	If "Yes," to any part of question # 2, please fully describe in the "Remarks" section including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.		

REMARKS	
Question No. and Letter	Details

Medical Examiner's Certification

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.
Name of Proposed Insured

Examined at _____, this _____ day of _____, 20_____, at _____ a.m./p.m.

Examiner's Name _____ ☐ Paramedic ☐ M.D. ☐ D.O.
Please Print

Examiner's Signature X _____ Examiner's Telephone No. - -

Examiner's SSN/TIN

Name of Paramedical Company | Company Telephone No. - -

Street Address

City | State | Zip Code

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