ANSWERS MADE TO THE MEDICAL EXAMINER

In continuation of and forming a part of application for insurance to

UNITED HOME LIFE INSURANCE COMPANY

P.O. Box 7192, Indianapolis, Indiana 46207-7192

Part II

Proposed Insured _____ (First Name / Middle Initial / Last Name)

Birth Date _____ (Month / Day / Year)

1. a. Name and address of your personal physician _____
   (If none, so state)
   b. Date and reason last consulted _____
   c. What treatment was given or medication prescribed? _____

	Yes	No
2. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gall-bladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐
k. Allergies; anemia or other disorder of the blood?	☐	☐
l. Used (other than prescribed by a physician) narcotics, LSD, cocaine, amphetamines, barbituates, or marijuana; or been dependent upon alcohol, drugs or narcotics (whether prescribed by a physician or not); or been treated, or been advised to seek treatment or counseling for alcohol or drug usage; or been arrested for DUI or substance violation?	☐	☐
m. Any mental or physical disorder not listed above?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. a. Have you used tobacco in any form in the past 12 months? If yes, indicate ☐ cigarettes ☐ cigars ☐ pipe ☐ chewing ☐ snuff	☐	☐
b. Have you used tobacco in any form in the past and quit? If yes, date last used? _____	☐	☐
6. Other than above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanitorium, or other medical facility?	☐	☐
c. Had electrocardigram, X-ray, other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
7. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
8. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐
9. Does anyone in your family have or have they ever had cancer, diabetes, heart, or kidney disease? If yes, give details:	☐	☐

	Age if living	Cause of Death	Age at Death
Father			
Mother			
Siblings			

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

10. Females only	Yes	No
a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	☐	☐
b. Are you now pregnant?	☐	☐

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____ (Month) , _____ (Year)

Witness _____ (Signature of Medical Examiner) M.D. _____ (Signature of Proposed Insured)

MEDICAL EXAMINERS REPORT

Part III

10a. Height (Incl Shoes) ft. in.	Weight Clothed lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	Details of "Yes" answers. (Identify item.)

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (Record All Readings)

Systolic			
Diastolic — 4th phase			
Diastolic — 5th phase			

12. Pulse

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below - if more than one, describe separately)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

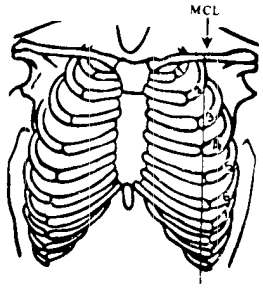
Indicate:

Apex by X

Murmur area by ◌

Point of greatest Intensity by O

Transmission by ➧



For your comments and your impression.

14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)	Yes	No
(a) Eyes, ears, nose, mouth, pharnyx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias? ☐ Yes ☐ No Any hemorrhoids?	☐	☐
16. (Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐
17. Are you alone with proposed insured and unrelated to both proposed insured and agent?	☐	☐

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to the Home Office? ☐ Yes ☐ No

NOTE: A specimen is to be sent to the appropriate laboratory on every application.

Name of Agent

I certify that I have carefully examined _____ of _____
(City and Street Address)

in private at ___ my office / his place of business / his home this _____ day of _____ (Month) , _____ (Year) at _____ A.M. P.M.

Signature of Examiner _____ Address _____

200-045 1-98

_____
(Please Print)