PURE EXAMINER INSTRUCTIONS

Thank you for helping us complete a PURE Exam. This process is the most private, exclusive, and successful way for clients to secure life insurance coverage. You were identified as an exceptional examiner, providing the best possible examination experience. We appreciate you taking the extra time to treat our clients just like we do. Your efforts can put a client at ease and eliminate any unpleasantness from the application process. If you have questions about how this process should go, please contact APPS at (866)245-0268 or ValMark Securities at (330)576-1234.

Completing a PURE Exam

Scheduling and Confirming the Appointment

- Most appointments will be pre-scheduled. If you are scheduling the appointment, please be sure to contact the applicant via the preferred method indicated on the order.
- Many of our clients prefer to have a spouse, agent, or assistant schedule the appointment, so be sure to review the order for any special instructions and identify the proper person to contact.
- Please phone or email the day before the appointment to provide a reminder. Provide the client your contact information so they can reach you should an issue come up prior to the appointment.
- If an EKG is to be completed, please remind the applicant they will need a private, comfortable place to complete this EKG, *especially if the exam is happening at their office.*
- If contacting the client for any reason via email, please be sure that the agent is copied on the communication.

The Appointment

- Be punctual. If you will not arrive on time, please notify the client by phone prior to the appointment time.
- Set clear expectations for the experience. Let the client know what events will happen and in what order.
- Be pleasant and professional. Most of our clients are successful business professionals and are truly appreciative when you do a great job.
- Gather complete and accurate medical information. Your medical knowledge can be powerful in asking the right follow-up questions or clarifying answers that may be inconsistent or inaccurate.
- The exam paperwork is unique to ValMark. Please review the format prior to the appointment to make sure it can be completed easily and completely. Paperwork should NEVER go in the lab kit-original paperwork should be mailed to APPS after a copy has been scanned or faxed.
- Given the busy schedules of our clients, we typically only have one opportunity to complete the exam. Be sure all pages are complete, signatures are gathered, and requirements satisfied before leaving the appointment. If all requirements cannot be satisfied, please immediately schedule a time to complete, either with you or with another examiner through the APPS Home Office.

Post Appointment: Paperwork and Lab Process/ Shipping

- Blood and Urine samples need to be processed immediately post collection and shipped to the lab within 24 hours.
- Scan or fax the exam paperwork to APPS by midnight on the same day the exam is completed.

PURE MEDICAL HISTORY

I. CLIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____/_____/_____ SS#: _____-_____-_____

Picture ID Verification Yes ☐ No ☐ Issuing State _____ Exp. Date _____

Driver's License # _____

II. PRIMARY CARE PROVIDER

Do you have a personal physician or primary care provider? Yes ☐ No ☐

Physician Name _____ Facility Name _____

Address _____ City_____ State_____ Zip _____

Date of last visit_____ Reason for visit _____

Tests Performed and Treatment Received: _____

Have you seen any other doctors in the last 5 years? *If so, please provide details in section VI*

Are you taking any prescription or non-prescription medications or drugs? Yes ☐ No ☐

Details (dosage, frequency): _____

_____

III. PERSONAL HISTORY

Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, e-cigarettes, a pipe, chewing tobacco, nicotine patches or gum)? Yes ☐ No ☐

Details (type, frequency, date of last use):_____

_____

Do you consume alcoholic beverages? Yes ☐ No ☐

Details (type, amount, frequency, date of last use):_____

_____

Do you participate in regular exercise? Yes ☐ No ☐

Details (type, amount, frequency):_____

_____

IV. MEDICAL HISTORY

For any YES answers, please provide complete details in section VI.

	YES	NO
Within the last 5 years have you:		
a) Been medically advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counseling or participated in a group for alcohol or drug use?	☐	☐
b) Tried or used cocaine, heroin, marijuana, barbiturates, or other controlled substances?	☐	☐
Have you ever been diagnosed by a member of the medical profession or medically treated for the following:		
c) High blood pressure, chest pain, coronary artery disease, congestive heart failure, heart attack, heart murmur, heart valve disease, or any other disease of the heart or arteries?	☐	☐
d) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease?	☐	☐
e) Diabetes, high blood sugar, glucose intolerance, thyroid disorder or disease of any other gland?	☐	☐
f) Depression, anxiety, any other mental or psychiatric illness or emotional disorder?	☐	☐
g) Alzheimer's disease, dementia, memory loss, epilepsy, paralysis, Multiple sclerosis, ALS (Lou Gehrig's disease), Parkinson's disease or disease of the brain or nervous system?	☐	☐
h) Cancer, tumor, polyp, lymphoma, Hodgkin's disease, or cyst?	☐	☐
i) Arthritis, gout, osteoporosis, fractures, or any other bone, joint or muscle disease?	☐	☐
j) Asthma, sleep apnea, emphysema, chronic obstructive pulmonary disease (COPD), shortness of breath, allergies or any other disease of the lung or respiratory system?	☐	☐
k) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, stomach, esophagus or intestines?	☐	☐
l) Disease of the prostate, testicles, uterus, cervix, ovaries, breasts or any sexually transmitted disease (other than HIV)?	☐	☐
m) Anemia, leukemia, bleeding or clotting disease, disease of the immune system, blood, blood cells, bone marrow or lymph nodes (other than HIV)?	☐	☐
n) Disease of the urinary tract, bladder, or kidneys?	☐	☐
o) Disorder of the eyes, ears nose or throat?	☐	☐
Within the last 10 years, have you been diagnosed by a member of the medical profession with the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
Other than above, have you in the last five years:		
p) Had any diagnostic tests, such as EKG, x-ray, stress test, echocardiogram, angiography, CT scan, MRI, EEG or blood studies (other than HIV)?	☐	☐
q) Been told by a physician that you have any other health impairment or medically treated condition?	☐	☐
r) Been a patient in a hospital or other medical facility, other than for normal childbirth?	☐	☐
s) Been advised to have surgery, medical tests or diagnostic procedures which were not completed?	☐	☐
t) Requested or received disability or compensation benefits?	☐	☐
Have you ever been rated or declined for life, disability, or long term care insurance?	☐	☐
Have you had a change in weight of 10 or more pounds in the last 12 months?		

Details (amount of change, reason): _____

V. FAMILY HISTORY

Please provide your family history, making note of histories of diabetes, cancer and heart disease

Family Member	Age	Health History	Age of Death	Cause of Death

VI. PLEASE GIVE DETAILS TO ALL 'YES' ANSWERS, INCLUDING DIAGNOSIS, TREATMENT, DOCTORS' NAMES, ADDRESSES AND DATES

Condition _____

Physician Name _____ Facility Name _____

Address _____ City _____ State _____ Zip _____

Date of last visit _____ Reason for visit _____

Tests Performed and Treatment Received _____

Condition _____

Physician Name _____ Facility Name _____

Address _____ City _____ State _____ Zip _____

Date of last visit _____ Reason for visit _____

Tests Performed and Treatment Received _____

Condition _____

Physician Name _____ Facility Name _____

Address _____ City _____ State _____ Zip _____

Date of last visit _____ Reason for visit _____

Tests Performed and Treatment Received _____

The information provided above is complete, true and accurately recorded, to the best of my knowledge.

_____ _____

Signature Date

PURE EXAMINER'S REPORT

I. CLIENT INFORMATION

Name: _____

Lab Name: _____ Lab Code: _____

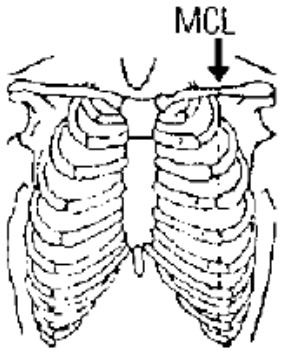
II. PRIMARY CARE PROVIDER

Measured Height (in shoes) _____feet _____ inches Measured Weight (in clothing) _____pounds

Blood Pressure: Reading 1 _____ Reading 2 _____ Reading 3 _____

Pulse (beats per minute): Reading 1 _____ Reading 2 _____

III. PERSONAL HISTORY



Check all conditions that apply: Enlargement ☐ Dyspnea ☐

Edema ☐ Murmur ☐

Provide description of murmur _____

_____

II. PERSONAL HISTORY

Albumin _____ Sugar _____

III. PERSONAL HISTORY

Was the urine sample sent to the lab? Yes ☐ No ☐ Was an EKG performed? Yes ☐ No ☐

Was the blood sample sent to the lab? Yes ☐ No ☐ Was a translator used? Yes ☐ No ☐

III. PERSONAL HISTORY

Examiner Name _____

Date and Time of Examination _____ Location of Exam _____

Paramedical/Examining Company Name _____

Branch Office Address and Phone Number _____

I hereby certify that I have personally examined the person named above in private and have correctly and fully reported my findings

_____ _____

Signature of examiner **Date**