Medical Questionnaire

Washington National Insurance Company
Home Office: 11825 N. Pennsylvania St.,
Carmel, Indiana 46032-4555

To be completed by the Medical Examiner, signed in his or her presence and witnessed by him or her.

PLEASE PRINT ALL ANSWERS

Proposed Insured: First M.I. Last	Birthdate: Month/ Day/ Year

1. a. Name and Address of your personal physician or medical provider(if none, state none) .....
b. Date and Reason last visited .....
c. What treatment was given or medication prescribed? .....

	Yes	No
2. Have you within the past 10 years been treated for or had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; depression, 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, congestive heart failure or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver, or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostrate, breasts or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, arthritis, 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?	☐	☐
3. Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or been told that you tested positive for HIV by a member of the medical profession?	☐	☐
4. Have you ever been advised by a physician to reduce your consumption of alcohol or drugs?	☐	☐
5. Have you ever sought advice or been treated for use of alcohol or drugs?	☐	☐
6. Within the past two years have you on the average consumed more than two alcoholic beverages each day or more than five alcoholic beverages on any occasion?	☐	☐
7. Within the past 10 years have you used (other than prescribed by a licensed physician) opium, heroin, barbiturates, sedatives, tranquilizers, marijuana, cocaine, amphetamines, hallucinogens, psychedelic drugs, LSD, DMT, mescaline, narcotics, stimulants, morphine, or any other controlled substance not prescribed for your use by a physician?	☐	☐
8. a. Have you used tobacco in the last 36 months?	☐	☐
If so what form(s)		
b. Date last used: (Month/Year)		
9. Are you now under observation or taking treatment?	☐	☐
10. Other than the above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanitarium, nursing home, long term care facility, or other medical facility?	☐	☐
c. Had electrocardiogram, X-ray, other diagnostic test	☐	☐
d. Been advised to have any diagnostic test, hospitalization, treatment, or surgery which was not completed?	☐	☐
11. Are you planning to consult a doctor for any physical symptoms you have experienced within the past 60 days?	☐	☐
12. Have you ever had military deferment, rejection or discharge because of a physical or mental condition?	☐	☐
13. Have you ever requested a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
14. Family History: Stroke, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐

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.

	Age if Living	Cause of Death?	Age at Death
Father			
Mother			
Brothers and Sisters No. Living _____ No. Dead _____			

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, the MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my family members proposed for insurance, or our health, to give the Company or its reinsurers, any such information it may require to determine eligibility for insurance. A photographic copy of the authorization shall be as valid as the original.

I represent that the above statements and answers are true and complete to the best of my knowledge and belief, and I agree that such statements and answers shall be part of the application and are made to induce the Company to issue the policy or contract applied for.

Dated at _____
City/State

On _____
Month/ Day/ Year

Signature of
Proposed Insured _____
Child's Parent if Proposed Insured is under age 16

Signature of
Medical Examiner _____

Medical Examiner's Report

Washington National Insurance Company
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15. Name (Please Print)

DETAILS of "Yes" answers. (Identify Item)

16. Height (In Shoes) ..... FT. IN. | Chest (Full Inspiration) ..... IN.
Weight (Clothed) ..... LBS. | Chest (Forced Expiration) ..... IN.
Abdomen, at Umbilicus relaxed ..... IN.

	Yes	No
a. Did you weigh?	☐	☐
b. Did you measure?	☐	☐
c. Weight change in past year?	☐	☐
☐ Gain ☐ Loss _____Lbs. – Cause?		
d. Is appearance unhealthy or older than stated age?	☐	☐

17. Blood Pressure (Record all readings)

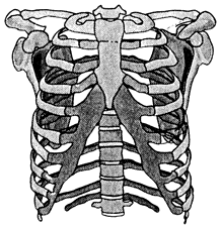
Systolic				
	4th phase			
Diastolic				
	5th phase			

18. Pulse		At Rest	After Exercise	3 Minutes Later
	Rate			
Irregularities Per Min.				

19. Heart

	Yes	No
a. Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder?	☐	☐
b. Is heart enlarged? (if yes, describe)	☐	☐
c. Is murmur present? (If yes, complete 19d)	☐	☐

d. Murmur is:
☐ Constant ☐ Inconstant ☐ Transmitted ☐ Localized
☐ Systolic ☐ Presystolic ☐ Diastolic ☐ Apical ☐ Aortic ☐ Other
☐ Soft (Gr. 1-2) ☐ Mod. (Gr. 3-4) ☐ Loud (Gr. 5-6)



e. After Exercise Murmur is:
☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

f. Show Location Of:
Apex by X
Area of murmur by ..... ☐
Point of greatest intensity.. O
Transmission ..... →

g. Your Impression?

20. Is there on examination any abnormality of the following: ..... **Yes** ☐ **No** ☐
(Circle applicable items and give details)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx (If vision or hearing markedly impaired, indicate degree and correction)	☐	☐
b. Skin (incl. Scars), lymph nodes, blood vessels (include varicose veins)	☐	☐
c. Nervous system (include reflexes, gait, paralysis)	☐	☐
d. Respiratory system	☐	☐
e. Abdomen (including scars)	☐	☐
f. Genitourinary system	☐	☐
g. Endocrine system (include thyroid and breasts)	☐	☐
h. Musculoskeletal system(include spine, joints, amputations, deformities)	☐	☐
21. a. Are there any hernias?	☐	☐
b. Any hemorrhoids?	☐	☐
22. Have you any pertinent information not brought out above?	☐	☐
Female Applicants: Are you currently in menses?	☐	☐

A Urine Specimen must be obtained with all exams and forwarded to :
☐ CRL ..... Barcode#:

Examiner must mail this form when completed direct to the Insurance Company: P.O. Box 1966, Carmel, IN 46082-1966
1-800-888-4918 / Fax 317-817-2343

I certify that I made the examination at | **Time** ☐AM / ☐PM | **Date** | **Location** ☐ my office ☐ individual's office ☐ individual's home ☐ Other

This examination should be made in private. If 3rd person present, give details

Examiner's Signature: | Examiner's Address:

Examiner's Phone: | Name of Agent: