Western Reserve Life Assurance Co. of Ohio
Home Office: Columbus, Ohio
Mailing Address: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
Administrative Office: PO Box 5068, Clearwater, FL 33758-5068

Medical Supplement Part II of WRL Express Application

19 PROPOSED INSURED INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth (Month/Day/Year) _____ Marital Status: _____

Social Security No. _____ Height (Ft., In.): _____ Weight (Lbs): _____

Name, address and telephone number of your primary care physician? (If none check box) ☐ None _____

_____

Date and reason last consulted? _____

What treatment was given or medication prescribed? _____

20 MEDICAL INFORMATION ABOUT THE PROPOSED INSURED

A) For the last 180 days have you been actively at work, on a full time basis, at your usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, have you within the last 10 years, had or been told by a member of the medical profession that you have, or been diagnosed with or treated for:
1) High blood pressure, heart attack, murmur, chest pain, palpitation, anemia, or any disease of the heart, blood vessels or blood? ☐ Yes ☐ No
2) Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
3) Cancer, tumor, polyp or cyst? ☐ Yes ☐ No
4) Sugar, protein, or blood in the urine, sexually transmitted disease, or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? ☐ Yes ☐ No
5) Stroke, seizure, epilepsy, fainting, loss of consciousness, tremor, paralysis, multiple sclerosis, or any disease of the brain or nervous system? ☐ Yes ☐ No
6) Anxiety, depression, suicide attempt, or any psychiatric, mental or nervous or emotional condition or disorder? ☐ Yes ☐ No
7) Diabetes, or any disease or abnormality of the thyroid, adrenal, pancreas, pituitary or other glands? ☐ Yes ☐ No
8) Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? ☐ Yes ☐ No
9) Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones or any physical deformity or amputation? ☐ Yes ☐ No
10) Any disease or abnormality of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No

C) To the best of your knowledge, have you within the last 10 years:
1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, have you been told by a member of the medical profession that you have or had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for the HTLVIII test? ☐ Yes ☐ No

E) Have you had a parent, brother, or sister, who has/had coronary artery or cardiovascular disease, internal cancer, or melanoma, prior to age 60? ☐ Yes ☐ No

F) Has your weight changed by more than 15 pounds in the past year? ☐ Yes ☐ No

21 DETAILS Give details for "No" answer to question 20A and all "Yes" answers to 20B, C, D, E and F

Question No.	Diagnosis, disease, symptom, injury, etc.	Dates	Duration	Treatments/Results?	Name and Address of Attending Physicians and Hospitals

22 CERTIFICATION

I represent that I have read and understand all the statements and answers herein, based on the information provided to the Company during a telephone interview on a recorded line or to this examiner; and in Part 1 of my application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded. I fully understand and agree that if any material information has been omitted from the application, it could provide the basis for the Company to rescind coverage and to refund all my premium as though my coverage had never been in force. I agree that this application and any policy or policies issued based on this application shall constitute the entire contract of insurance. Acceptance of the policy by me is acknowledgment and ratification of any corrections made in the application. I further acknowledge that the information contained in Parts 1 and 2 of this form is being obtained on behalf of Western Reserve Life Assurance Co. of Ohio and that such information will be released to the Company, its agents, employees, representatives and reinsurers.

Date _____ _____
Signature of proposed Insured

_____ _____
Signature of Examiner Print Examiner's Name

Western Reserve Life Assurance Co. of Ohio

EXAMINATION OF: (Print full name) _____

MEDICAL EXAMINATION REPORT - PART II
PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS IN "DETAILS' SPACE BELOW

23. Height		24. Weight		25. Girth-Chest		26. Girth
Ft.	In.	Present	1 Yr. Ago	Inap.	Exp.	Abdomen

27. Temperature	28. Pulse Rate	IF PULSE IS IRREGULAR, complete exercise test, question 33f, below

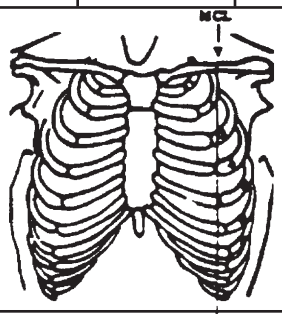
29. Blood Pressure	Systolic	Diastolic (Phase V)	IF BLOOD PRESSURE IS ABNORMAL, record additional reading after 5 minutes.
1st Reading			
Additional			

On inquiry and examination is there evidence of:	YES	NO
30. Present or past disease or abnormalities of:	☐	☐
a. Brain, nervous system? (test reflexes; coordination)	☐	☐
b. Eye, ears, nose, throat, teeth, gums?	☐	☐
c. Thyroid or lymph glands?	☐	☐
d. Lungs or respiratory system?	☐	☐
e. Stomach or abdominal organs?	☐	☐
f. Genito-urinary systems?	☐	☐
g. Skin, skeletal structure or extremities?	☐	☐
31. Varicose veins or ulcers?	☐	☐
32. Arteriosclerosis; other peripheral vascular disease?	☐	☐
33. Presence of past diseases or abnormalities of heart or blood vessels? (if "Yes", complete questions 33a through g.)	☐	☐

a. Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?	☐	☐
b. Is there hypertrophy? (If "Yes", state degree)	☐	☐
c. Is there a murmur?	☐	☐
Type: ☐ Systolic ☐ Diastolic ☐ Presystolic — Quality: ☐ Soft ☐ Rough ☐ Blowing — Intensity: ☐ Faint ☐ Moderate ☐ Loud — Location: ☐ Apex ☐ Aortic ☐ Pulmonic		
d. Is murmur constant?	☐	☐
e. Is murmur transmitted?	☐	☐
If "Yes", where? _____		

f. EXERCISE TEST - 50 vigorous hops	Pulse Rate	Irregularities No. per minute	Murmur Present	Murmur Absent
Before exercise				
Immediately after				
3 minutes after				

g. PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:
Position of apex beat.....
(_____ Ins. or _____ cms. from midsternum in _____ interspace)
Murmur:
Area of distribution ..... ☐
Point of greats intensity ..... ○
Direction of transmission..... ›



34. Urinalysis See note below	Specific Gravity	Albumin	Sugar

	YES	NO
a. Are you satisfied specimen is authentic?	☐	☐
b. Are you forwarding Specimen?	☐	☐
c. Have you completed with this exam:		
An EKG?	☐	☐
Blood Profile?	☐	☐
TVC?	☐	☐
35. Have you any pertinent information affecting proposed Insured not brought out above?	☐	☐

DETAILS

MEDICAL EXAMINER: _____

YES	NO	
☐	☐	Are you in any way related to the proposed Insured or Insurance Producer? *If yes, give details.*

_____

YES	NO	
☐	☐	Was the examination conducted in a language other than English? *If yes, indicate language used and if applicable, name & relationship of person acting as interpreter.*

_____

Name of Insurance Producer requesting examination: _____

INSTRUCTIONS Complete all questions above. You must ask the proposed Insured each question and record the answer.

No examiner has any authority to issue a certificate of health or to declare the proposed Insured acceptable for Insurance. Under our rules, only the Company's underwriting department has authority to determine the insurability of the applicants for insurance.

Mail the specimen for laboratory analysis to the laboratory listed on the collection kit or as instructed by your paramedical company.

EXAMINATION WAS MADE AT:

☐ My Office

☐ Residence of proposed Insured

☐ Place of Business of proposed Insured

☐ Other: _____

At _____ AM/PM on _____

Others present (indicate None or list name/relationship):

_____

_____

SIGNATURE OF EXAMINER _____

Print Examiner name: _____

Company Branch #: _____

Tax Identification Number: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone No.: _____

If mailing, send to: Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Road NE
Cedar Rapids, IA 52499
AWD Fax #: 1-800-814-2205