PART TWO

STATEMENTS TO THE MEDICAL EXAMINER

In Continuation of and Forming a Part of My Application for Insurance to

WICHITA NATIONAL LIFE

711 SW D AVENUE • Lawton, Oklahoma 73501 • Phone 1-580-353-5776

Use Dark Ink Only

Proposed Insured (Please Print)	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? _____

2. Have you been treated for or had known indication of any of the following? CIRCLE IMPAIRMENT and give details.

If question is answered "YES", give full details.
Condition? When? Duration? Results? Doctor(s) or Medical Facility

	Yes	No
a. CARDIO-VASCULAR SYSTEM		
High blood pressure; artery or vein disorder	☐	☐
Heart attack, angina, chest pain, heart murmur	☐	☐
b. ENDOCRINE SYSTEM		
Diabetes, thyroid or gland disease	☐	☐
c. RESPIRATORY SYSTEM		
Bronchitis, asthma, emphysema	☐	☐
d. DIGESTIVE SYSTEM		
Colitis, ulcers, rupture; stomach or intestinal disorder	☐	☐
Liver, spleen or gall bladder disease	☐	☐
e. GENITO-URINARY SYSTEM		
Disorder of breast, prostate, ovaries, uterus or reproductive organs	☐	☐
Sugar, albumin, blood or pus in urine	☐	☐
Colic, stones, stricture; kidney or bladder disease	☐	☐
f. MUSCULO-SKELETAL SYSTEM		
Arthritis; disorder of muscle, bone, joints or skin	☐	☐
g. E E N T SYSTEM		
Eye or ear impairment	☐	☐
h. NERVOUS SYSTEM		
Hemorrhage, stroke, paralysis	☐	☐
Convulsions, dizziness; brain, nervous or mental disorders	☐	☐
i. GENERAL		
Cancer, tumor, cyst, blood disorder	☐	☐
Any other disease, disorder, injury or physical impairment?	☐	☐

3. Other than as stated above, have you ever:	Yes	No
a. Consulted or been treated by any physician(s) or practitioner(s) or been hospitalized in past 3 years?	☐	☐
b. Had or been advised to have surgical operations, X-ray treatment, Electrocardiogram, X-ray, or other laboratory studies?	☐	☐
4. Do you now use or have you ever used or been treated for usage of:		
a. Heroin, Morphine or other narcotic drugs?	☐	☐
b. L.S.D., Marijuana, Cocaine or other similar agents?	☐	☐
c. Alcoholic beverages to excess?	☐	☐
5. Have you ever:		
a. Applied for or received any kind of disability compensation?	☐	☐
b. Been declined, postponed or limited for any life or other insurance or reinstatement thereof?	☐	☐
6. Have you had an insurance examination done within last 30 days for any other company?	☐	☐
7. Has your weight changed in past year? No. Lbs._____ Gained? ☐ Lost? ☐	☐	☐
8. Are you now taking any medication or treatment?	☐	☐
9. Are you in good health and free from impairment?	☐	☐

10. Family History	Age if Living	Age at Death	State of Health or Cause and Date of Death
Father			
Mother			
Brothers and Sisters No. Living			
Brothers and Sisters No. Dead			

I hereby declare that all statements and answers as written herein and in Part One of this application are full, complete and true, whether by my own hand or not, and I agree that they are to be considered the basis of any insurance issued hereon.

Dated at _____ this _____ day of _____, 20____

Witness _____
Examiner

Signature in full of Proposed Insured or Parent or Guardian for Proposed Insured

3011-280

PART THREE

MEDICAL EXAMINER'S REPORT

This Report is Confidential Between Company and Examiner.

To be completed in private by Examiner only.

Examination of heart and lungs must be with stethoscope against bared skin.

Name

1. **BUILD** (MALES ONLY):

HEIGHT (IN SHOES) FT.	HEIGHT (IN SHOES) IN.	WEIGHT (CLOTHED) LBS.	CHEST (FULL INSPIRATION) IN.	CHEST (FORCED EXPIRATION) IN.	ABDOMEN (AT UMBILICUS RELAXED) IN.

a. Did you weigh? ☐ Yes ☐ No b. Did you measure? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

2. **BLOOD PRESSURE** (Record all readings)
If resting blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided:

	AT REST	AFTER 50 HOPS	3 MINUTES LATER	REPEAT B.P.
SYSTOLIC				
DIASTOLIC 5TH PHASE				
3. **PULSE RATE**				
Irregularities Per Min.				

4. HEART a. Is there any cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No
b. Is heart enlarged? ☐ Yes ☐ No (If yes, describe)
c. Is murmur present? ☐ Yes ☐ No (If yes, complete 4d)

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

After exercise: ☐ Unchanged ☐ Increased
☐ Decreased ☐ Absent

Show Location Of:

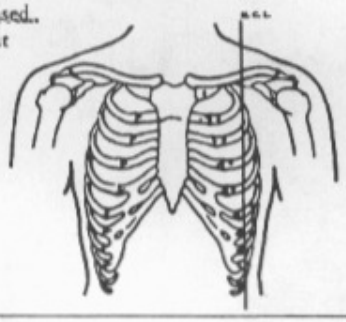
Apex by X

Area of murmur by ◌

Point of greatest intensity by O

Transmission by →

Your impression?



5. Is there on examination any abnormality of the following: (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. Endocrine system (include thyroid and breasts)	☐	☐
c. Nervous system (include reflexes, gait, paralysis)	☐	☐
d. Respiratory system	☐	☐
e. Abdomen (including scars)	☐	☐
f. Genito-urinary system (include prostate)	☐	☐
g. Skin (incl. scars), lymph nodes, blood vessels (incl. varicose veins)	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)	☐	☐
6. Are there any hernias, hemorrhoids?	☐	☐
7. Have you any pertinent information not brought out above?	☐	☐

8. URINALYSIS:

SPECIFIC GRAVITY	ALBUMIN	SUGAR

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

Send specimen to Home Office: If Applicant is 51 years of age or over, amount applied for or total amount this Company is over $100,000, or in case of findings or history of any urinary or circulatory abnormality.

Details of "Yes" answers. (Identify item.)

TO EXAMINER: Mail this completed examination directly to:
Wichita National Life Insurance Co.
P.O. Box 1709
Lawton, Oklahoma 73502

I certify that I, _____ made this examination at _____ ☐ A.M. _____ ☐ P.M. on the _____ day
Examiner's Name (Please Print)
of _____, 20____

Where was exam done? _____ Examination authorized by: _____

Examiner's Social Security or Tax Identification Number must be furnished under authority of law _____

Examiner's signature _____ Examiner's address _____

3011-280