Woodmen of the World/Omaha Woodmen Life Insurance Society

A Fraternal Benefit Society OMAHA, NEBRASKA

PART III - Paramedical Examination

Proposed Insured's Name for Life Insurance

First MI Last

Date of Birth Social Security No.

Certificate No. Amount Applied For

Field Representative's Name Code

TO BE COMPLETED BY THE PROPOSED INSURED

1. Name and address of your personal physician? If none, check box ☐ _____

2. A. When did you last consult a physician? If not the personal physician, include name & address _____

   B. What symptoms or complaints did you have? _____

   C. What diagnosis was made and what treatment was prescribed? _____

3. Are you now taking any medication? Yes ☐ No ☐ If Yes, give name, dosage and reason for, if different from above information _____

4. Have you had any other illness or injury not mentioned above? Yes ☐ No ☐ If Yes, give details to include diagnosis, date, duration, treatment and name of attending physician. _____

5. In the past 12 months, have you used tobacco in any form, such as cigarettes, pipe, cigars, snuff, or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? Yes ☐ No ☐
   If Yes, date last used Mo. _____ Yr. _____ Indicate form(s) used: _____ If cigarettes, how many ppd? _____
   Have you ever used cigarettes in the past? Yes ☐ No ☐ If Yes, when did you quit? _____

The foregoing answers are true and complete to the best of my knowledge.

_____ _____

(Date) (Signature of Proposed Insured)

TO BE COMPLETED BY THE EXAMINER

6. A. Height _____ B. Weight _____ C. # Lost Past Year _____
   D. Did you measure and weigh the person? _____ E. Weight Limit for your Scale _____
7. Blood Pressure: (If above 140/90 report additional readings five minutes apart)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____

8. Pulse Rate: _____ Is it regular? _____ (If no, please describe) _____
9. If female, is applicant currently menstruating? Yes ☐ No ☐

➪ Age 13 and over, forward urine specimen to lab assigned to your paramedical company.

Affix paramed address or stamp Company name here & Phone no.

I understand that tests other than those specifically requested are not authorized, and will not be paid for by the Society. I have verified the identity of this applicant.

Signature of Examiner _____ Date _____ Daytime Phone No. _____

Printed Signature _____

Address _____ City _____ State _____ Zip _____

Form 5015 R-2/2001