



ANSWERS MADE TO THE MEDICAL EXAMINER

In continuation of and forming a part of application for insurance to
MOUNTAIN LIFE INSURANCE COMPANY Post Office Box 240 - Alcoa, Tennessee 37701

Proposed Insured _____ Birth Date: _____
 First Name Middle Initial Last Name Month Day Year

1. a. Name and address of your personal physician _____
- b. Date and reason last consulted _____
- c. What treatment was given or medication prescribed? _____

2. Have you been treated for or had any known indication of:	Yes	No
a. Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
b. Dizziness, fainting, convulsions, severe or frequent headache, speech defect, paralysis or stroke; mental or nervous disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath, persistent hoarseness or cough, blood spitting, chronic bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? ..	<input type="checkbox"/>	<input type="checkbox"/>
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of the kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes; thyroid or other endocrine disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
i. Deformity, lameness or amputation?	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of skin, breasts, lymph glands; cyst, tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
k. Allergies; anemia or other disorder of the blood?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any care or treatment or medical advice for alcohol usage? ..	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you used any of the following more than twice: Amphetamines, barbiturates, hallucinogenics, narcotics or marijuana? If prescribed for you by a physician, please explain	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you smoked cigarettes, cigars, or pipe tobacco within the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Other than above, have you used any other tobacco product in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you now under observation or taking treatment? List medications, with dosage, any special diet within the last 5 years. Give dates	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any change in weight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
9. <i>Other than above</i> , have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a checkup, consultation, illness, injury, surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had electrocardiogram, X-ray, other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Ever applied for or received any pension or benefits for sickness, disability or accident?	<input type="checkbox"/>	<input type="checkbox"/>
g. Are you taking any medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
10. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you participate in regular exercise? If yes, describe type and frequency .	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, 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 & Sisters			
No. Living _____			
No. Dead _____			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____, 20 _____

Witness _____
 (Signature of Medical Examiner) Title (Signature of Proposed Insured, or Signature of Parent or Guardian if Proposed Insured is a Minor)

MEDICAL EXAMINER'S REPORT

12. Pulse _____ per/minute Regular Irregular
Number of Irregularities, if any _____

13. Blood Pressure 1st Reading 2nd Reading 3rd Reading
Systolic _____
Diastolic _____

To be taken at separate intervals and if systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest. Then take 2 additional readings.

14. Height _____ (without shoes)

18. Urinalysis (Dipstick)

15. Weight _____

a. Glucose _____
b. Albumin _____

16. Did you weigh? Yes No

17. Did you measure? Yes No

19. Obvious abnormalities:

20. Remarks:

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Medical Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at _____ on _____ 20 _____

Witnessed by _____
Examiner

Signature of Person Examined _____

Examination Branch Address :
(Please print or use stamp)

I certify that I have carefully examined _____

of _____ on this _____ day of _____ 20 _____ @ _____ am / pm
Street Address, City

Signature of Examiner _____ Date _____ Address _____