

- ☐ Hartford Life Insurance Company
- ☐ Hartford Life and Annuity Insurance Company
Hartford, CT 06104-2999



MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

INSTRUCTIONS FOR THE MEDICAL EXAMINER — DETACH AND DISCARD BEFORE MAILING THE COMPLETED EXAMINATION TO THE COMPANY

- 1.) If you are related to the proposed insured being examined or to the agent, **PLEASE DO NOT PERFORM THIS EXAMINATION.** Please immediately advise the agent and the paramedical company so other arrangements can be made.
- 2.) Please perform the examination in private.
- 3.) **PLEASE RECORD ALL INFORMATION LEGIBLY IN YOUR OWN HANDWRITING, IN BLACK INK.**
- 4.) Please complete the Senior Exam Supplement (pages 5 and 6) on all applicants age 71 or over.
- 5.) Please cut the word flashcards (page 7) and arrange them in order as noted on the form prior to doing the Senior Exam Supplement.
- 6.) If there are any alterations or changes on pages 1, 2 or 3, the proposed insured being examined must initial them. If you have any alterations on page 4, you must initial them yourself.
- 7.) If you have any other medical information which may have a bearing on the insurability of this proposed insured, please list it on this exam questionnaire, or on a separate piece of paper and mail it with the examination to our Company.
- 8.) This examination, once begun, is the property of the Company. Please do not destroy or delay sending it to the Company.
- 9.) Fees will be paid by the Company.



MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

PLEASE USE BLACK INK ONLY

1) Name of Proposed Insured _____ Date of Birth _____
Residence (City and State) _____

2) Primary Physician, Health Care Provider or Clinic:
Name _____ Address _____

Phone Number _____
Date of Last Visit _____

Reason for Last Visit (Please include details of evaluation, treatment and/or referrals made.)

NOTE: GIVE DETAILS TO ALL "YES" ANSWERS ON NEXT PAGE

		Yes	No
3.	Do you take any prescription, over the counter medication or herbal remedy? (If "Yes," please provide names and doses.)	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever had, been treated for or had treatment recommended by a member of the medical profession for:		
a.	High Blood Pressure; Heart Murmur or Heart Valve Abnormality; Chest Pain; Heart Surgery; Heart Attack; Abnormal Heart Rhythm; other Heart or Vascular Disease, Condition or Disorder; Stroke or Mini-Stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Cancer, Tumor or other abnormal growth; Recurrent Infections; Lymph Gland Swelling or Enlargement; Immune System Disease, Human Immunodeficiency Virus (HIV) Infection, or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Diabetes or other Endocrine Disease; Condition or Disorder (e.g. thyroid, adrenal, pituitary, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Anemia; Blood Transfusion; Blood Vessel Disease; other Blood Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Dizziness; Fainting or Loss of Consciousness; Alzheimer's Disease or Dementia; Epilepsy or Seizure Disorder; Brain or Spinal Cord Disorder; other Nervous System Disease; Depression, Anxiety, Stress or Panic Attacks; or other Psychological Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f.	Asthma, Chronic Bronchitis or Emphysema; other Lung Disease, Condition or Disorder; Sleep Apnea or Narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>
g.	Disease of the Esophagus, Pancreas or Stomach; Ulcerative Colitis or Crohn's Disease; Chronic Indigestion, Diarrhea or Vomiting; Hepatitis or other Disease of the Liver; Hernia, other Gastrointestinal Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h.	Bladder Disease; Kidney Disease; Prostate Disease; Sugar, Protein or Blood in the Urine; Breast Disease; other Genitourinary Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i.	Rheumatoid Arthritis, Lupus, other Connective Tissue Disease, Condition or Disorder; Arthritis, Rheumatism or other Joint Disease, Condition or Disorder; Disease, Condition or Disorder of Bones, Back or Spine; Disease, Condition, or Disorder of Muscles, Ligaments or Tendons?	<input type="checkbox"/>	<input type="checkbox"/>
j.	Ear Disease or Eye Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k.	Chronic Fatigue, Fibromyalgia or Myalgia?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you engage in regular exercise? (If "Yes," provide details).	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you lost 10 or more pounds in the last 6 months (not due to change in diet)?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you, in the past 5 years, used any illicit drug or prescription drug that was not prescribed by a physician? (If "Yes," provide details to include treatment recommended or given.)	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you currently consume alcoholic beverages? (If "Yes," how many per day and per week?)	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Females only: Are you currently pregnant? (If "Yes," what is your due date?)	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONNAIRE APPLICATION SUPPLEMENT

14.	Family History	Living or Deceased	Current Age or Age at Death	Health History (include age at onset)	Cause of Death
	Father				
	Mother				
	Siblings				

DETAILS OF "YES" ANSWERS (Please attach additional sheet if more space is needed.)

Question Number	Diagnosis, reason for visit, treatment, medication, hospitalization, surgery, advice	Dates of onset and recovery	Name, address, and phone number of doctor, health care provider, clinic or hospital

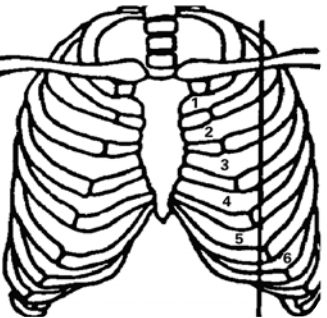
I agree that, to the best of my knowledge and belief, the information herein is complete and true and shall be the basis for and a part of any insurance issued.

Dated at _____ **Date** _____
 City **State** **Month** **Day** **Year**

Witness _____
 Signature of Examiner/Agent **Signature of Person examined**

Medical Examiner's Report

1) _____ Height _____ Weight Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/>	2) Blood Pressure: take 3 readings <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="padding: 2px;">Systolic</td> <td style="width: 50px; height: 20px;"></td> <td style="width: 50px; height: 20px;"></td> </tr> <tr> <td style="padding: 2px;">Diastolic</td> <td style="width: 50px; height: 20px;"></td> <td style="width: 50px; height: 20px;"></td> </tr> </table>	Systolic			Diastolic			3) Pulse: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="padding: 2px;">Rate</td> <td style="width: 50px; height: 20px;"></td> </tr> <tr> <td style="padding: 2px;">Irregularities/mn.</td> <td style="width: 50px; height: 20px;"></td> </tr> </table>	Rate		Irregularities/mn.	
Systolic												
Diastolic												
Rate												
Irregularities/mn.												

<p>4) Please use the space provided to give details of the physical exam (→)</p> <p>Cardiovascular Exam — Is there any evidence of:</p> <p>a.) Peripheral Vascular Disease Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Abnormal or diminished pulse <input type="checkbox"/> carotid <input type="checkbox"/> other pulse <input type="checkbox"/> Other signs of PVD</p> <p>b.) Enlarged heart ----- Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c.) Heart murmur ----- Yes <input type="checkbox"/> No <input type="checkbox"/> Murmur is <input type="checkbox"/> Constant <input type="checkbox"/> Transmitted <input type="checkbox"/> Systolic <input type="checkbox"/> Apical <input type="checkbox"/> Inconstant <input type="checkbox"/> Localized <input type="checkbox"/> Presystolic <input type="checkbox"/> Basal <input type="checkbox"/> Trace (0-I) <input type="checkbox"/> Mild (II) <input type="checkbox"/> Diastolic <input type="checkbox"/> Other <input type="checkbox"/> Trace (0-I) <input type="checkbox"/> Mild (II) <input type="checkbox"/> Moderate (III) <input type="checkbox"/> Loud (IV)</p> <p>Show Location of: --Apex by ----- X Area of Murmur by ----- ○ Point of greatest intensity by ----- ○ Transmission by ----- →</p> <p>Your impression? _____</p>	<p style="text-align: center;">Details of Questions 1 - 9 USE ONLY FOR QUESTIONS ON THIS PAGE</p> <div style="text-align: center;">  </div>
d.) Other CV disease (describe) _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	

5) Are there any abnormalities on examination of: a.) Eyes Yes <input type="checkbox"/> No <input type="checkbox"/> b.) Ears Yes <input type="checkbox"/> No <input type="checkbox"/> c.) Mouth, Pharynx Yes <input type="checkbox"/> No <input type="checkbox"/> d.) Skin, Lymph Nodes Yes <input type="checkbox"/> No <input type="checkbox"/> e.) Blood Vessels Yes <input type="checkbox"/> No <input type="checkbox"/>	f.) Nervous System Yes <input type="checkbox"/> No <input type="checkbox"/> g.) Lungs Yes <input type="checkbox"/> No <input type="checkbox"/> h.) Abdomen, Liver, Spleen, Kidney Yes <input type="checkbox"/> No <input type="checkbox"/> i.) Musculoskeletal System Yes <input type="checkbox"/> No <input type="checkbox"/>
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6) Is the person's appearance unhealthy or older than stated age? Yes <input type="checkbox"/> No <input type="checkbox"/>	7) Do you have any information or observations relating to this person's physical or mental health that are not already recorded? (If "yes," please give details.) Yes <input type="checkbox"/> No <input type="checkbox"/>
8) If female, is this person menstruating today? Yes <input type="checkbox"/> No <input type="checkbox"/>	

9) Urinalysis	SPECIFIC GRAVITY	ALBUMIN	SUGAR

****SEND SPECIMEN TO LAB IN ALL CASES****

I certify that I have carefully examined _____ whose statements and signature appearing on the reverse side hereof, were made and signed in my presence and that the examination was made in private at My office, Applicant's residence, Applicant's place of business, this _____ day of _____, _____
 Examined at _____ M. D. or D. O.
 City State (Medical Examiner's Signature)

This examination must bear the actual date that the exam was completed and no other.
 Examiner Name (Print) _____ Paramedical Co. Name _____
 Address _____
 Phone Number _____
 Name of Agent _____ Agent's Phone Number _____



SENIOR EXAM SUPPLEMENT

Instructions for the examiner:

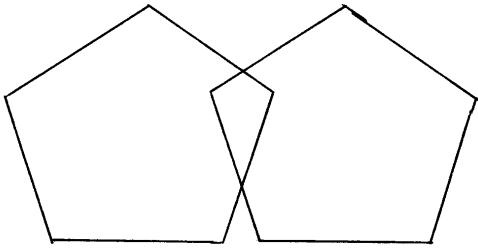
PLEASE COMPLETE FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

- | | |
|-----|--|
| 1a. | <p>Read aloud the instructions below to the Proposed Insured. Then read aloud each of the words on the list, one at a time, while showing the corresponding flashcard, and ask the proposed insured to make up a sentence using each word. The proposed insured may not record anything on paper. It is not necessary to record the proposed insured's response; draw a line through any word that the proposed insured cannot use in a sentence.</p> <p><i>In this part of the survey, I will read a word while showing the word to you. Please use each word in a sentence. The sentence may be as long or as short as you like. Later I am going to ask you to recall the words. Do you have any questions?</i></p> |
| 1b. | <p>Follow the same instructions as for Part a. Read aloud the instructions below. When done, place the flashcard out of sight. Note the time and allow at least 5 but not more than 15 minutes before proceeding to #6.</p> <p><i>Now I am going to repeat the same words as before, show you the words and again ask you to use each in a sentence. You may make up a new sentence or use the same sentence that you used before. Do you have any questions?</i></p> |
| 2. | <p>Read instructions to the proposed insured and record number of seconds/minutes it takes to complete the task. The proposed insured must stand up from a seated position without using the arms of the chair for help, walk 10 feet, turn around and sit down.</p> <p><i>Please complete this exercise: Stand up without using the arms of the chair, walk to <u>(insert place in the room that is 10 feet away)</u>, turn around, walk back, and sit down.</i></p> |
| 3. | <p>Ask the proposed insured about the activities listed. Record details of answers, giving specifics of activities they do perform and reasons for ones they are unable to perform or able to perform only with assistance.</p> |
| 4. | <p>Ask the proposed insured if they perform any regular exercise. Record details, including duration and frequency.</p> |
| 5. | <p>Record details of any falls, including circumstances, injuries, and treatment.</p> |
| 6. | <p>Read instructions to the proposed insured. <u>Record all words, including words not on the list</u> that the applicant recalls. DO NOT read the words to the proposed insured; this must be done from memory. AT LEAST 5 MINUTES BUT NO MORE THAN 15 MINUTES MUST HAVE ELAPSED FROM PARTS 1a AND 1b BEFORE DOING THIS ACTIVITY.</p> <p><i>A few minutes ago I read some words to you and you used them in sentences. Please repeat to me as many words as you can recall.</i></p> |
| 7. | <p>Read the instructions to the proposed insured. Allow 60 seconds for the task. Straight edge or ruler is not allowed.</p> <p><i>Please duplicate the following drawing.</i></p> |

Upon completion of the examination, provide any additional information or observations within the details section of the answer page. Verify that the client name and date of birth, and your signature are on the Senior Supplement. Return the answer page with the other examination paperwork. Discard this instruction page and the flashcards prior to mailing any and all examination paperwork or specimens.

SENIOR EXAM SUPPLEMENT

PLEASE COMPLETE THE FOLLOWING FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

Name of Proposed Insured:		Date of Birth:	
1a.	Follow the instructions for question 1a. Draw a line through any word below that the proposed insured cannot use in a sentence: Book Flower Train Rug Meadow Salt Finger Park Chimney Button	DETAILS SECTION: Please indicate the question number and all details below.	
1b.	Please repeat the task in 1a exactly, using the words in the same order. Book Flower Train Rug Meadow Salt Finger Park Chimney Button		
2.	Please ask the proposed insured to stand up, not using the arms of the chair, walk 10 feet, turn around, walk back and sit down. Record the amount of time from start to finish: _____		
3.	Is the proposed insured able to do the following without assistance? Record details at right.		
	A. Clean home, do yard work? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	B. Shop (food, clothes, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	C. Drive, travel? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	D. Manage finances (pay bills, balance check book, etc)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
4.	Does the proposed insured engage in any type of regular exercise (walking, treadmill, running, aerobics, swimming, strength training, etc.)? Record details at right. Yes <input type="checkbox"/> No <input type="checkbox"/>		
5.	Has the proposed insured fallen at any time in the last 2 years? Record details at right. Yes <input type="checkbox"/> No <input type="checkbox"/>		
6.	Please ask the proposed insured to repeat as many words as they can recall from #1 above. Record responses to the right.		
7.	Please ask the proposed insured to draw the figure below in the space at the right. <div style="text-align: center;">  </div>		

I certify that I have personally asked all of the questions and accurately recorded responses and results.

Signature of examiner Date Print name of examiner

Book

Salt

Flower

Finger

Train

Park

Rug

Chimney

Meadow

Button