**USE BLACK INK**

# MEDICAL EXAMINER'S REPORT

In continuation, and forming a part, of the application for insurance to:

☐ THE WESTERN AND SOUTHERN LIFE INSURANCE CO.

☐ WESTERN AND SOUTHERN LIFE ASSURANCE CO.

## A—STATEMENTS TO THE EXAMINER

Proposed Insured _____
First name Middle initial Last Name

Birth Date: Month Day Year

1. a. Name and address of Proposed Insured's personal physician?
**(If none, so state)** _____
b. Date and reason last consulted? _____

| | Yes | No |
|---|---|---|
| 2. Has the Proposed Insured ever been treated for or ever had: | | |
| a. Disorder of eyes, ears, nose or throat? | ☐ | ☐ |
| b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder? | ☐ | ☐ |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? | ☐ | ☐ |
| d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? | ☐ | ☐ |
| e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? | ☐ | ☐ |
| f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? | ☐ | ☐ |
| g. Diabetes; thyroid or other endocrine disorders? | ☐ | ☐ |
| h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? | ☐ | ☐ |
| i. Deformity, lameness or amputation? | ☐ | ☐ |
| j. Disorder of skin or lymph glands; cyst, tumor, or cancer? | ☐ | ☐ |
| k. Allergies; anemia or other disorder of the blood? | ☐ | ☐ |
| **3. Other than above,** has the Proposed Insured within the past 5 years: | | |
| a. Had any mental or physical disorder? | ☐ | ☐ |
| b. Had a checkup, consultation, illness, injury, surgery? | ☐ | ☐ |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? | ☐ | ☐ |
| d. Had electrocardiogram, X-ray, other diagnostic test? | ☐ | ☐ |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? | ☐ | ☐ |
| 4. During his or her entire lifetime, has the Proposed Insured used marijuana, LSD, barbiturates, cocaine, heroin or other narcotic, or other habit-forming drug, or been diagnosed, treated, or advised to be treated for alcoholism or drug use? | ☐ | ☐ |
| 5. During his or her entire lifetime, has the Proposed Insured been diagnosed by a health care professional as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex); received treatment from a health care professional for AIDS or ARC; or tested positive for antibodies to the AIDS virus [Human Immunodeficiency Virus (HIV-1) or Human T-Cell Lymphotropic Virus, Type III (HTLV-III)]? | ☐ | ☐ |
| 6. Has the Proposed Insured ever had military service deferment, rejection or discharge because of a physical or mental condition? | ☐ | ☐ |
| 7. Has the Proposed Insured ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? | ☐ | ☐ |

8. Any family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ☐ ☐

| 9. | Age if Living | Cause of Death? | Age at Death? |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers and Sisters | | | |
| No. Living<br>No. Dead | | | |

10. Has the Proposed Insured used tobacco during the past 12 months?
☐ Yes ☐ No
If "Yes", indicate type of tobacco product used, how much is used, or date when the use of any tobacco product ceased:

11. Dates of last menstrual period?

**DETAILS** of "Yes" answers. **IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS.** Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

I hereby declare, before affixing my signature hereto, I read the answers to the above questions, the answers as above written are as given by me in response to the questions; and, to the best of my knowledge and belief, all the answers are complete and true. I further declare no information has been concealed or withheld concerning past or present state of health and habits of the Proposed Insured. **Ohio Law requires the following for Ohio applicants:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Signed at _____ _____ _____ _____
City mm/dd/yyyy Medical Examiner Sign as Witness Signature of Proposed Insured (if under age 15, Parent or Guardian

FORM DO-12-9110

## MEDICAL EXAMINER: PLEASE COMPLETE VOUCHER

### RULES FOR MEDICAL EXAMINER

1. Each item of information requested has a bearing on the insurability of the applicant and each question has been most carefully considered before its insertion in the examination form.
2. Ask each question as it is written and be sure that the import of each one is fully understood. Give full particulars on your report when the answer "Yes" or "No" does not cover the information sought.
3. Use black ink.
4. Do not use dashes or ditto marks for answers.
5. If related to Agent or applicant, do not examine.
6. Examinations should be made without Agent present.
7. Do not make "Test" or "Preliminary" examinations.

FORM DO-12-9110

**TO BE FILLED IN BY MEDICAL EXAMINER**

### MEDICAL EXAMINER'S VOUCHER
### WESTERN-SOUTHERN LIFE, CINCINNATI, OHIO 45202

| | |
|---|---|
| NAME OF PROPOSED INSURED | DATE OF BIRTH |
| DATE OF EXAMINATION | NAME OF DISTRICT REQUESTING EXAMINATION |
| NAME OF COMPANY EXAMINER OR PARAMEDICAL COMPANY (PLEASE TYPE OR PRINT TO ASSURE PROPER PAYMENT) Portamedic Direct #404 312-217-4761 M.D. | |
| NUMBER AND STREET 312 Meadow Green Ln | |
| CITY AND STATE Round Lake Beach, IL 60073 | ZIP CODE |

**ORDER AND APPOINTMENT FOR MEDICAL EXAMINER**

☐ THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY
☐ WESTERN-SOUTHERN LIFE ASSURANCE COMPANY

**DATE**

DISTRICT _____ ACCT. NO. _____ OFFICE CODE _____

☐ ORDINARY NEW BUSINESS ☐ MAO NEW BUSINESS ☐ POLICY CHANGE ☐ REVIVAL ☐ POLICY NUMBER _____

**To Medical Examiner** _____ at _____

Name of Person
To be Examined _____ Age _____

Reason for Examination _____

Home Address _____ Phone _____

Business Address _____ Phone _____

Proposed Insured _____

**DO NOT DETACH**

To be examined at:
☐ Your Office
☐ Residence
☐ Place of Business
Date of Exam _____
Time _____ ☐ A.M. ☐ P.M.
☐ Applicant will phone
☐ Phone Applicant

**COMPLETE FOR LIFE ONLY**

Face Amt. or Selected Amt. Applied for $ _____
Supp. Term $ _____
Total Amt. Applied for $ _____
Ord. In Force With W-S $ _____
Total $ _____

If total is $100,000 or more for ages 55 and below or $25,000 or more for ages 56 and above, check the proper for the age in section 18 below.

## B—STATEMENT OF THE EXAMINER'S FINDINGS

1. a. Height (In Shoes) ft. in. | b. Weight (Clothed) lbs. | c. Has weight changed in the past year? ☐ Yes If "Yes" indicate _____ lbs. Lost ☐ No _____ lbs. Gained

d. Did you weigh? ☐ Yes ☐ No e. Did you measure? ☐ Yes ☐ No
f. Is appearance unhealthy or older than stated age? ..... ☐ Yes ☐ No

2. Blood Pressure (Record ALL readings.) — If initial blood pressure is elevated, repeat at end of examination.

| | | | |
|---|---|---|---|
| Systolic | | | |
| Diastolic-5th phase | | | |

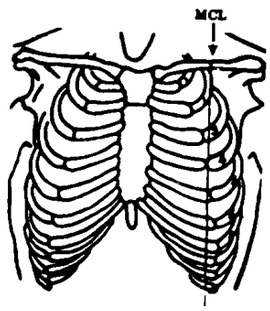
3. a. Pulse rate _____ per min.
b. If pulse rate is 90 or over retake on held inspiration while bending forward. Pulse Rate _____ per min.
c. Irregularities in pulse
At rest _____ per min.
After exercise _____ per min.

4. Heart: Do you find any: Murmur(s)
At rest ☐ Yes ☐ No
After exercise ☐ Yes ☐ No
Location of murmur _____ indicate:

Enlargement ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No
Edema ☐ Yes ☐ No

Constant ☐
Inconstant ☐
Transmitted ☐
Localized ☐
Systolic ☐
Presystolic ☐
Diastolic ☐
Soft (Gr. 1-2) ☐
Mod. (Gr. 3-4) ☐
Loud (Gr. 5-6) ☐
After exercise: ☐
Increased ☐
Absent ☐
Unchanged ☐
Decreased ☐

Apex by X
Murmur area by ✿
Point of greatest intensity by O
Transmission by ➧




For comments and 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) Skin (include scars); lymph nodes; varicose veins or peripheral arteries? ..... | ☐ | ☐ |
| (c) Nervous system (include reflexes, gait, paralysis)? ..... | ☐ | ☐ |
| (d) Respiratory system? ..... | ☐ | ☐ |
| (e) Abdomen (include scars)? ..... | ☐ | ☐ |
| (f) Genitourinary system? ..... | ☐ | ☐ |
| (g) Endocrine system (include thyroid and breasts)? ..... | ☐ | ☐ |
| (h) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... | ☐ | ☐ |
| 6. (a) Are there any hernias? ☐ Yes ☐ No. (b) Any hemorrhoids? ..... | ☐ | ☐ |
| 7. Are you aware of additional medical history? ..... (A confidential report may be sent to the Medical Director.) | ☐ | ☐ |

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

8. Urinalysis: Albumin | Sugar

Is specimen being sent to laboratory?
☐ Yes ☐ No

9. SEND SPECIMEN TO LABORATORY ONLY IF:
☐ Age 55 or less—Amount $100,000 or over in force plus applied for
☐ Age 56 or over—Amount $25,000 or over in force plus applied for
☐ Abnormal contents on urinary examination, or systolic pressure 150 or higher
☐ History or findings of a cardiac or renal disorder
☐ Home Office request

## SPECIAL ATTENTION

REMARKS:

I certify that I made this examination at _____ ☐ A.M. _____ ☐ P.M. DATE _____

Examination made at ☐ My office, ☐ Proposed Insured's office, ☐ Proposed Insured's home, ☐ Other: _____

Examiner's signature: _____ Examiner's address: _____
(No. & Street) (City) (State) (Zip Code)