

Proposed Insured _____ Date of Birth _____
 (First Name Middle Initial Last Name) (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? _____

	Yes	No	
2. Have you ever been treated for or ever had any known indication of:			DETAILS of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration, outcome, names, addresses and telephone numbers of all attending physicians and medical facilities.
a. Disorder of eyes, ears, nose, or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis, stroke, mental, or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Shortness of breath, persistent hoarseness or cough, blood spitting, 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, hepatitis, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Nephritis, kidney stone, any disease or disorder of the kidneys or bladder, any tumor or disease of the prostate, testes, breast, uterus, ovaries, or complications of pregnancy?	<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	<input type="checkbox"/>	<input type="checkbox"/>	
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, lymph glands, cyst, tumor, or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
k. Allergies, anemia or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Within the past 10 yrs, to the best of your knowledge have you had or: Been diagnosed by a member of the medical profession as having or been tested positive for, or been treated by a member of the medical profession for any of the following: Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Human Immunodeficiency Virus (HIV), or any other disease or disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Any mental or physical disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you smoked cigarettes in any amount in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
6. In the past ten years, have you used:			
a. Alcoholic beverages to excess or intoxication?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Barbiturates, sedatives, or tranquilizers habitually?	<input type="checkbox"/>	<input type="checkbox"/>	
c. L.S.D., marijuana, cocaine, or any amphetamine?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Heroin, morphine, or other narcotic drug?	<input type="checkbox"/>	<input type="checkbox"/>	
7. In the past ten years, have you been treated for alcoholism or any drug habit?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are you now under observation or taking treatment or medication?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you had any change in weight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Other than above, have you within the past 5 years:			
a. Had a checkup, consultation, illness, injury, or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had electrocardiogram, x-ray, other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you ever had military deferment, rejection or discharge because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you ever requested or received a pension, benefits, or payment because of injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Family History: Have any of your parents, brothers, or sisters ever had heart disease, cancer, diabetes, or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	

14. Family Information	Age if Living	Age at Death	Cause of Death	Number Living	Number Deceased
Father					
Mother					
Brothers and Sisters					

I hereby declare that all statements and answers given above are full, complete and true to the best of my knowledge and belief; and I agree that they, with the statements on my application, will be considered the basis of any insurance issued.

Signed at _____ (City or Town, State) Date _____ (Month Day Year)

Signature of Medical Examiner _____ Signature of Person Examined _____
 TLIC 80301 (07/2009)

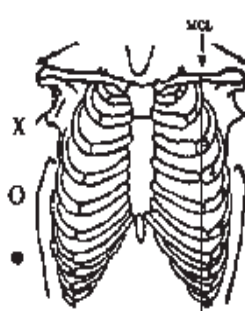
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PART THREE

MEDICAL EXAMINER'S REPORT

15a. Height (In Shoes)	Weight (Clothed)	Circumference (Males Only)			Details of "Yes" answers. (Identify item.)
		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen Umbilicus	
ft. in.	lbs.	in.	in.	in.	
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Is appearance unhealthy or older than stated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
16. Blood Pressure: (If blood pressure is above 140/90, record two additional readings after 10 minute rests.)					
		Systolic	Diastolic (Phase V)		
1 st Reading					
2 nd Reading					
3 rd Reading					
17.					
Pulse		At Rest	After Exercise	3 Minutes Later	
Rate					
Irregularities per min.					
18. Heart: Is there any:					
Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No		Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No			
Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No		Edema <input type="checkbox"/> Yes <input type="checkbox"/> No			
(describe below — if more than one, describe separately)					
Location	1st MURMUR	2nd MURMUR	Indicate:		
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by 		
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>			
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>			
Localized	<input type="checkbox"/>	<input type="checkbox"/>			
Systolic	<input type="checkbox"/>	<input type="checkbox"/>			
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>			
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>			
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>			
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>			
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>			
After exercise:			■ If a murmur is present, ask if there is any rheumatic or other type of infection; ■ What do you think is the cause of this murmur?		
Increased	<input type="checkbox"/>	<input type="checkbox"/>			
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>			
Decreased	<input type="checkbox"/>	<input type="checkbox"/>			
19. On examination is there any abnormality of the following (Circle applicable items and give details.)					
			Yes	No	
(a) Eyes, nose, mouth, pharynx?			<input type="checkbox"/>	<input type="checkbox"/>	
(b) Skin (including scars); lymph nodes; varicose veins or peripheral arteries?			<input type="checkbox"/>	<input type="checkbox"/>	
(c) Nervous system (include reflexes, gait, paralysis)?			<input type="checkbox"/>	<input type="checkbox"/>	
(d) Respiratory system?			<input type="checkbox"/>	<input type="checkbox"/>	
(e) Abdomen (including scars)?			<input type="checkbox"/>	<input type="checkbox"/>	
(f) Genitourinary system?			<input type="checkbox"/>	<input type="checkbox"/>	
(g) Endocrine system (include thyroid and breasts)?			<input type="checkbox"/>	<input type="checkbox"/>	
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?			<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any hernias?			<input type="checkbox"/>	<input type="checkbox"/>	
21. Are you aware of additional medical history?			<input type="checkbox"/>	<input type="checkbox"/>	
(A confidential report may be sent to the Medical Director.)					
22. Urinalysis: Specific Gravity _____ Albumin _____ Sugar _____					

Examiner: Print Name: _____ Signature: _____

Print name of person examined: _____ Date of examination: _____

Parmedical or medical firm name/address: _____