

**STATEMENTS TO THE MEDICAL EXAMINER**

In Continuation of and Forming a Part of My Application for Insurance to  
**Pioneer American Insurance Company**

**PART TWO**

Mail examination to: Underwriting Department / P.O. Box 240 / Waco, Texas 76703-0240

1. Applicant (Please Print) _____	Birth Date: Month Day Year / /	Driver's License #  SS#      —      —	State
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2. (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? \_\_\_\_\_  
 (d) List all current medications including herb and vitamin supplements. \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 3. To the best of your knowledge and belief do you have, or have you had, or been treated in the past 10 years for (circle condition that applies):   |                          |                          |
| (a) Asthma, pneumonia, bronchitis, emphysema, tuberculosis or any disease or disorder of the lungs or respiratory system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Dizziness, epilepsy, seizure, paralysis, head injury, or any mental or nervous disorder? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Albumin, protein, sugar or blood in urine; any disease or disorder of the kidneys or genitourinary system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Arthritis or any disease or disorder of the muscles, bones, joints, or back? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Any disease or disorder of the ears, eyes, nose or throat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Chest pains, heart attack, stroke, transient ischemic attack (TIA), high blood pressure, shortness of breath, heart murmur, phlebitis, blood clot; any disease or disorder of the heart or circulatory system? .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Cirrhosis, hepatitis, or any disease or disorder of the gastrointestinal tract? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Malignancy, cancer or other tumors or cyst? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Diabetes, thyroid, or endocrine disorders? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Anemia or any disease or disorder of the blood? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any disease or disorder of the immune system in the past 10 years? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever used:<br>Heroin, morphine, cocaine, LSD, marijuana or abused prescription medication? (If Yes, indicate amount and how often and date last used) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. (a) Do you currently drink alcohol? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, circle type: beer, wine, liquor. Indicate amount and frequency)  |                          |                          |
| (b) Have you ever received treatment for excessive drug or alcohol usage? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, give date of treatment and last usage)   |                          |                          |
| 7. (a) Have you been arrested in the past 10 years? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (If Yes, give details to include when, where, charges, and final outcome)   |                          |                          |
| (b) Have you had a DWI or DUI or had your Driver's License suspended or revoked in the past 10 years? (If Yes, explain) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a tattoo? (If Yes, date done) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the past 5 years, have you consulted, or been treated or examined by any physician, psychologist, psychiatrist or practitioner not named above for any cause not recorded above? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you used tobacco or any nicotine products in any form within the past twelve (12) months? (If Yes, type and amount, if No, date last used) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If the applicant is a woman: Are you currently menstruating? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the natural parent, brother or sister of the proposed insured ever had tuberculosis, diabetes, cancer, heart disease, kidney disease or mental illness? ...   | <input type="checkbox"/> | <input type="checkbox"/> |

**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.)**

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Siblings			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief. I agree that these statements and answers are to be considered as the basis of any insurance written hereon.

**AUTHORIZATION**

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has knowledge or records of me and my health to give such information to Pioneer American Insurance Company and its reinsurers. A copy of this authorization shall be as valid as the original. This authorization shall remain valid for 24 months from this date.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ Year

Witness \_\_\_\_\_ X \_\_\_\_\_ Signature of Applicant

**PART THREE**

**MEDICAL EXAMINER'S CONFIDENTIAL REPORT**

13. (a) Height (In Shoes)  ft.    in.	Weight (Clothed)  lbs.	Males Only:			Details of "Yes" answers (identify item).
		Chest (Full Inspiration)  in.	Chest (Forced Expiration)  in.	Abdomen, at Umbilicus  in.	
(b) Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		(c) Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Is appearance unhealthy or older than stated age? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Pulse:					
Rate		At Rest	After Exercise	3 Minutes Later	
Irregularities per min.					
16. Blood Pressure:					
Systolic		1 _____	2 _____	3 _____	
Diastolic (5th phase, end of sound)		_____			
If over 140 or 90 or under treatment report several readings.					
17. Is applicant presently under anti-hypertensive medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**PHYSICIAN STATEMENT**

18. Is there evident arteriosclerosis?     Yes     No

19. 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	Murmur 1	Murmur 2	Indicate:	
Constant	<input type="checkbox"/>	<input type="checkbox"/>		MCL ▼
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	X
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	○
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest	○
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	intensity by	○
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	▶
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:				
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Absent	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		

For comments and your impression



20. Is there on examination any abnormality of the following: (Circle applicable items and give details.)	<b>Yes</b>	<b>No</b>
(a) Eyes, ears, nose, mouth, pharynx? .....	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree.)		
(b) Skin (include 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? .....	<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"/>
21. Are there any hernias? .....	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you aware of additional medical history? .....	<input type="checkbox"/>	<input type="checkbox"/>

(A confidential report may be sent to the Medical Director.)

Urinalysis: Specific Gravity	Albumin	Sugar	<b>IMPORTANT</b> Please forward urine and/or blood specimen(s) to the Laboratory shown on the container provided.
(a) Is specimen being sent? <input type="checkbox"/> Yes <input type="checkbox"/> No			(b) Blood Study: Is sample being sent to lab shown on container? <input type="checkbox"/> Yes <input type="checkbox"/> No

I CERTIFY I made this examination in private at     My office,     Applicant's office,     Applicant's home.    at \_\_\_\_\_     A.M.     P.M.  
in \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_,

Signature: \_\_\_\_\_ Address: \_\_\_\_\_  
Medical Examiner