STATEMENTS TO THE MEDICAL EXAMINER

In Continuation of and Forming a Part of My Application for Insurance to

Pioneer Security Life Insurance Company

PART TWO Mail examination to: Underwriting Department / P.O. Box 2550 / Waco, Texas 76702-2550

1. Applicant (Please Print)	Birth Date: Month Day Year / /	Driver's License #	State
		SS# __ __	

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?	☐	☐
(b) Dizziness, epilepsy, seizure, paralysis, head injury, or any mental or nervous disorder?	☐	☐
(c) Albumin, protein, sugar or blood in urine; any disease or disorder of the kidneys or genitourinary system?	☐	☐
(d) Arthritis or any disease or disorder of the muscles, bones, joints, or back?	☐	☐
(e) Any disease or disorder of the ears, eyes, nose or throat?	☐	☐
(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?	☐	☐
(g) Cirrhosis, hepatitis, or any disease or disorder of the gastrointestinal tract?	☐	☐
(h) Malignancy, cancer or other tumors or cyst?	☐	☐
(i) Diabetes, thyroid, or endocrine disorders?	☐	☐
(j) Anemia or any disease or disorder of the blood?	☐	☐
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?	☐	☐
5. Have you ever used: Heroin, morphine, cocaine, LSD, marijuana or abused prescription medication? (If Yes, indicate amount and how often and date last used)	☐	☐
6. (a) Do you currently drink alcohol? (If Yes, circle type: beer, wine, liquor. Indicate amount and frequency)	☐	☐
(b) Have you ever received treatment for excessive drug or alcohol usage? (If Yes, give date of treatment and last usage)	☐	☐
7. (a) Have you been arrested in the past 10 years? (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)	☐	☐
8. Do you have a tattoo? (If Yes, date done)	☐	☐
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?	☐	☐
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)	☐	☐
11. If the applicant is a woman: Are you currently menstruating?	☐	☐
12. Has the natural parent, brother or sister of the proposed insured ever had tuberculosis, diabetes, cancer, heart disease, kidney disease or mental illness?	☐	☐

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 Security Life 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 _____
Examiner Signature of Applicant

PART THREE **MEDICAL EXAMINER'S CONFIDENTIAL REPORT**

13. (a) Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

(b) Did you weigh? ☐ Yes ☐ No (c) Did you measure? ☐ Yes ☐ No

14. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

15. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
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? ☐ Yes ☐ No

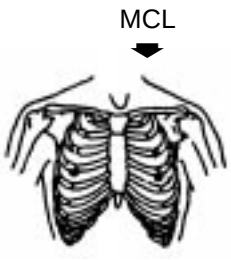
PHYSICIAN STATEMENT

18. Is there evident arteriosclerosis? ☐ Yes ☐ No

19. Heart:
Is there any:
Enlargement? ☐ Yes ☐ No Dyspnea? ☐ Yes ☐ No
Murmur(s)? ☐ Yes ☐ No Edema? ☐ Yes ☐ No
(Describe below — if more than one, describe separately.)

Location	Murmur 1	Murmur 2
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	☐	☐

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



For comments and your impression

20. 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.)	☐	☐
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
21. Are there any hernias?	☐	☐
22. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)	☐	☐

Details of "Yes" answers (identify item).

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

I CERTIFY I made this examination in private at ☐ My office, ☐ Applicant's office, ☐ Applicant's home. at_____ ☐ A.M. ☐ P.M.

in_____this_____day of_____, _____
City State

Signature: _____ Address: _____
Medical Examiner

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