



S.USA LIFE INSURANCE COMPANY, INC.

PART II APPLICATION FOR LIFE INSURANCE (Answers to Medical Examiner)

[P.O. Box 1050, Newark, NJ 07101-1050]			<u> </u>	[Toll Free: 866-SUSA-123 (866-787-2123)]					[www.susa.com]		
1.	(a) Proposed Insured (please print)										
	First Name M.I. Last Name										
	(b) Birth Date	(b) Birth Date / /				(d) Weight					
	N	// /onth/Day/Year	-	ft.	in.		lbs.				
2.	(a) Print name, address and	d phone number of yo	our personal physicia	n.		•					
	First Name	Last Name		Phone Number (include area code)							
	Number & Street					State	Zip Code				
	(b) Date and reason you las Month/Day/Year Reason			(c) T	reatment or recommendati	on:					
3.	Have you within the past 5 y			1				Yes	No		
	 (a) Had a physical examination, sought treatment or consulted a physician or other member of the medical profession for any reason? (b) Had any surgery? (c) Been treated for or been diagnosed by a member of the medical profession as having any illness or injury? (d) Been a patient in a hospital, clinic, or other medical facility? (e) Had electrocardiogram, X-ray, or other diagnostic test (except for HIV)? (f) Been advised by a member of the medical profession to have any diagnostic test, hospitalization, treatment or surgery (except for HIV) which was not completed? 										
4.	Have you ever been treated for or been diagnosed by a member of the medical profession as having:										
	• •	(a) Disease or disorder of eyes, ears, nose or throat?									
	(b) Dizziness, fainting, seizures, paralysis or stroke, memory loss, mental or nervous disease or disorder?(c) Shortness of breath, spitting up blood, bronchitis, asthma, emphysema, tuberculosis or other chronic respiratory disease or disorder										
	(d) Chest pain, palpitations or disorder of the heart	(d) Chest pain, palpitations, irregular heartbeat, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?									
	(e) Ulcer, colitis, intestinal bleeding, jaundice, rectal bleeding or any disease or disorder of the stomach, intestines, liver or gallbladder?										
					f kidney, bladder, prostate,						
	(g) Polyp, cyst, tumor, or cancer?										
	• • •	(h) Diabetes, thyroid or any other endocrine or glandular disorder or disease?									
		(i) Disease or deformity of the skin, cytomegalovirus, oral thrush or other fungal or opportunistic infection?									
	(j) Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back or joints?										
		(m) Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?									

5.	Are you now under observation or under treatment or taking medication for any reason?	Yes	No					
6.	Have you ever:							
	a) used narcotics, barbiturates, amphetamines, hallucinogens, other controlled substances, or any prescription drug except in accordance with a physician's instructions?							
othe	(b) received counseling or been treated by a member of the medical profession for alcoholism, or any drug habit, or for the use of any other substance?							
7.	Have you ever been retired or deferred from, or rejected for, military service or employment because of a physical, mental, or other impairment?							
8.	Has any parent or sibling:							
	(a) died of cancer or cardiovascular disease prior to age 60?	. 🗆						
	(b) been diagnosed by a member of the medical profession with cancer or cardiovascular disease prior to age 60 ?							
	If answered "yes" to (a) or (b), indicate relationship, age, and specify condition:							
9.	Has the Proposed Insured used tobacco in any form? (Including but not limited to cigarettes, cigars, pipe tobacco, chewing tobacco and In the last 12 months							
10.	Explain any "Yes" answers to Questions 3 through 8. Give names and addresses of all physicians and/or medical practitioners consuclinics, or medical facilities in which the Proposed Insured has been treated, observed or confined. Include conditions, tests, dates, district treatments and medications. Attach an additional sheet of paper if necessary. Question # Explanation Explanation		ospitals,					
To the best of my knowledge and belief, the statements herein are true, fully and correctly recorded, and made for the purpose of inducing the Company to issue insurance on my life. This Part II Application for Life Insurance and any paramedical/medical exam will be attached to and become part of the policy.								
X	Signature of Proposed Insured							
X	Signature of Medical Examiner Signed in my presence: Month/Day/Year							