Legal & General AMERICA
Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428
www.LGAmerica.com

1. Name of Proposed Insured _____ Date of Birth _____

PHYSICIAN INFORMATION

2. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

3. **Physician Last Consulted** ☐ Same as Primary Physician

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

4. **Family History** (Provide details to Yes answers in Question 5 below or use Remarks section, Question 27.)

	Yes	No
Has a parent or sibling ever been diagnosed, or treated by a member of the medical profession, for heart or kidney disease, stroke, diabetes, cancer, melanoma, substance abuse, suicide, sickle cell disease, Huntington disease, familial Alzheimer disease, familial adenomatous polyposis or FAP, amyotrophic lateral sclerosis (ALS or Lou Gehrig disease), or spinocerebellar ataxia?	☐	☐

5. **Complete the Family History chart below.**

	Age if Living	Medical Conditions (if Any)	Age at Onset/Event	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

PART 2 - Medical History (continued)

Name of Proposed Insured _____

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider name and address, date of onset, last consultation, symptoms, diagnosis and treatment.	Yes	No	**Remarks - Explain All Yes Answers** Enter question number before detailed response.
Questions 6-20, have you ever been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for:			
6. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, aneurysm, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐	
7. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, Barrett's Esophagus, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, rectum or anus?	☐	☐	
8. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, lupus, or lymphoma (excluding HIV)?	☐	☐	
9. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐	
10. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐	
11. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐	
12. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐	
13. Any sexually transmitted disorders or diseases?	☐	☐	
14. Asthma, shortness of breath, chronic cough or hoarseness, chronic bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐	
15. A disorder of the brain, back, spinal cord, or nervous system including Alzheimer's, dementia, memory loss, chronic headaches, chronic back pain, paralysis, tremors, convulsions, loss of consciousness, seizures, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack), or any other disorder of the brain, back, spinal cord, or nervous system?	☐	☐	
16. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐	
17. Arthritis, connective tissue disorder, fibromyalgia, chronic fatigue syndrome or disorder of the joints, bones, spine, skin, or muscles or loss of extremity or deformity?	☐	☐	
18. Any disease or disorder of the eyes, ears, nose, mouth, throat, head or neck?	☐	☐	
19. Females only: a. Have you ever been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for any disease or disorder of the uterus, cervix, ovaries, breasts, reproductive system, infertility, or complications of a pregnancy? b. Are you currently pregnant? If now pregnant, provide expected date of delivery in Remarks section.	☐ ☐	☐ ☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
20. Males only: Have you been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for any disease or disorder of the prostate, breasts, or reproductive system, including Klinefelter syndrome?	☐	☐	
21. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐	
22. Have you ever:			
a. Used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician? If Yes, provide dates of last use, name of drug(s) used, amount and frequency of use in the Remarks section.	☐	☐	
b. Been addicted to prescription medication? If Yes, provide dates of last use, name of medication(s) used, amount and frequency of use in the Remarks section.	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician, other licensed medical practitioner, or legal authority to undergo counseling, consult or treatment for drug or related problems?	☐	☐	
d. Attended or joined any organization due to drug or related problems?	☐	☐	
23. Have you ever:			
a. Consumed alcoholic beverages? If Yes, please advise: Frequency: (daily/weekly)_____ Type: (beer, wine, liquor) _____ Number of drinks: (or ounces) _____	☐	☐	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician, other licensed medical practitioner, or legal authority to undergo counseling, any consult or treatment for alcohol or related problems?	☐	☐	
d. Attended or joined any organization due to alcohol or related problems?	☐	☐	
24. In the **last 5 years,** unless previously stated on this application, have you:			
a. Been treated, examined, or advised by a member of the medical profession for any disease or disorder not previously stated on this application?	☐	☐	
b. Had an electrocardiogram, x-ray, Pap smear, Human papillomavirus (HPV) test, blood test, or other diagnostic test, excluding an HIV test?	☐	☐	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	☐	☐	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has NOT yet been completed?	☐	☐	
e. Been referred to any other member of the medical profession or medical facility?	☐	☐	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	☐	☐	
25. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?	☐	☐	
b. Taking any herbal or non-prescription medication at least weekly? If yes, provide details in the Remarks section.	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	**Remarks - Explain All Yes Answers**
26. Have you taken <u>any other medications</u> in the **past 2 years** not previously mentioned on this application? ..... If Yes, provide details in the Remarks section.	☐	☐	

27. Additional Remarks (please indicate which question number Remarks reference).

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than as written on this document.

_____ Signed at _____ on ____/____/_____

Signature of Proposed Insured | City/State | Date

PART 2 - Medical Examiner's Report (continued)

Name of Proposed Insured _____ Date of Birth _____

Instructions to the Examiner -

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

1. Height (in shoes) _____ ft. _____ in.
   Weight (clothed) _____ lbs.
   a. Did you weigh? Yes ☐ No ☐
   b. Did weight change by more than 10 lbs. in past year? Yes ☐ No ☐
      If Yes, indicate amount and reason in Remarks section, page 6.
   c. Did you measure? Yes ☐ No ☐
      If No, please explain _____
      _____

2. Measurements (males only)
   Chest (full inspiration) _____in.
   Chest (forced expiration) _____in.
   Abdomen (at umbilicus) _____in.

3. Blood Pressure (record 3 readings)
   Systolic
   Diastolic

4. Pulse At rest _____
   Describe any irregularities (number per minute, etc.)
   _____
   _____

5. Are blood and urine specimens being collected and mailed to the lab? Yes ☐ No ☐

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx?	☐	☐	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries?	☐	☐	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)?	☐	☐	
d. Respiratory system?	☐	☐	
e. Stomach, abdominal organs?	☐	☐	
f. Is the liver enlarged or tender?	☐	☐	
g. Genitourinary system?	☐	☐	
h. Musculoskeletal system (including spine, joints, amputations and deformities)?	☐	☐	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.)	☐	☐	

PART 2 - Medical Examiner's Report (continued)

7. To be completed if number 6.i. is answered Yes or if requested:

		Yes	No	Remarks
a.	Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	☐	☐	
b.	Are there any abnormalities of the first (S1) or second (S2) heart sounds?	☐	☐	
c.	Are there gallops (S3 or S4)?	☐	☐	
d.	Is/are there ejection sound(s) or systolic click(s)?	☐	☐	
e.	Is/are there murmur(s) present? If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	☐	☐	
8. a.	Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?	☐	☐	
b.	Does the Proposed Insured appear in any way unhealthy or older than the stated age?	☐	☐	
9. a.	Were you acquainted with the Proposed Insured prior to this examination? If Yes, fully describe the relationship in Remarks.	☐	☐	
b.	Are you the Proposed Insured's personal physician?	☐	☐	
c.	Was the examination conducted in a language other than English? If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.	☐	☐	
d.	Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured?	☐	☐	

10. How did you identify the Proposed Insured? ☐ Driver's license ☐ Other _____

Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.
Name of Proposed Insured

Examined at _____,
Street address, City and State

this _____ day of _____, 20_____ at _____ AM/PM.

Print Examiner's name _____ Signature of Examiner _____

☐ Paramed ☐ MD ☐ D.O.

Paramed Company _____ Telephone number _____

Address _____