TIAA CREF
Financial Services

TIAA-CREF LIFE INSURANCE COMPANY

[New Business Administration Office: P.O. Box 1291, 8500 Andrew Carnegie Boulevard, Charlotte, NC 28262-1291]

[Home Office: 730 Third Avenue, New York, NY 10017-3206]

LEVEL TERM LIFE INSURANCE APPLICATION – PART II
MEDICAL REPORT

Please Print in Black or Blue Ink

INSTRUCTIONS TO EXAMINER

This examination is the property of TIAA-CREF Life Insurance Company and must not be destroyed or suppressed. Please weigh the applicant and answer all questions below. If the answer is "Yes" to any of the questions listed below, provide full details in the "Remarks" section.

Section A: Proposed Insured

Full Legal Name (Title, First, Middle, Last, Suffix)		
Residential Address		Apt. No.
City	State	Zip Code
Gender ☐ M ☐ F	Date of Birth	Social Security #

Section B: Medical History

1. PRIMARY CARE PHYSICIAN			
Name	Telephone No.		
Address			
City	State	Zip Code	
a. Date of last consult with this physician?	m m d d y y y y		
b. Reason for last consult with this physician?			
c. Test(s) performed and treatment received?			
2. IN THE PAST 10 YEARS, HAS A LICENSED MEMBER OF THE MEDICAL PROFESSION PROVIDED YOU WITH ANY TREATMENT, MEDICAL ADVICE, CONSULTATION OR FOLLOW-UP FOR, OR DIAGNOSED YOU WITH:			
a. High blood pressure, elevated cholesterol, chest pain, angina, heart attack, heart disease, heart murmur, palpitations, stroke, peripheral vascular disease, cerebrovascular disease, or any other disorder of the heart or circulatory system?		☐ Yes	☐ No
b. Diabetes, glucose intolerance, thyroid or pituitary disorder or any other endocrine or glandular disorder?		☐ Yes	☐ No
c. Tumors, malignant or benign, cancer, melanoma or any other disease of the skin, lymphoma, enlarged lymph nodes, leukemia or any other malignant disorder?		☐ Yes	☐ No
d. Asthma, shortness of breath, COPD, emphysema, pneumonia, bronchitis, tuberculosis, sleep apnea, or any other disorder of the respiratory system?		☐ Yes	☐ No
e. Depression, anxiety, panic attacks, ADD/ADHD, emotional disorder, or any other psychiatric disorder or disturbance?		☐ Yes	☐ No
f. Seisure disorder, fainting, dizziness, multiple sclerosis, paralysis, or any other neurological disorder of the brain or nervous system?		☐ Yes	☐ No
g. Hepatitis, cirrhosis, or any other liver disorder?		☐ Yes	☐ No
h. Ulcerative colitis, Crohn's disease, gastrointestinal bleeding, gastric or peptic ulcer, acid reflux disease, Barrett's esophagus disease, or disorder of the stomach, pancreas, gall bladder, or any other intestinal disorder?		☐ Yes	☐ No

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Section B: Medical History (Continued)

2. IN THE PAST 10 YEARS, HAS A LICENSED MEMBER OF THE MEDICAL PROFESSION PROVIDED YOU WITH ANY TREATMENT, MEDICAL ADVICE, CONSULTATION OR FOLLOW-UP FOR, OR DIAGNOSED YOU WITH:		
i. Albumin, protein, blood or sugar in the urine or any disorder of the kidney, bladder, breasts, ovaries, prostate or other reproductive organs?	☐ Yes	☐ No
j. Any sexually transmitted diseases (except HIV)?	☐ Yes	☐ No
k. Gout, arthritis, connective tissue disease, immune system disorder (except for HIV) or any other disease or disorder of the joints, muscles, nerves or bones?	☐ Yes	☐ No
l. Anemia, clotting or platelet disorder, chronic infections, or any other disease or disorder of the blood?	☐ Yes	☐ No
m. Any disorder of the eyes, ears, nose, or throat?	☐ Yes	☐ No
3. Are you currently pregnant?	☐ Yes	☐ No
If Yes, what is the expected date of delivery? m m d d y y y y		
4. Has your weight changed by more than 10 lbs during the past 12 months?	☐ Yes	☐ No
If Yes, please provide reason for the weight change; if you gained or lost weight; and how much. lbs.	☐ Gain	☐ Loss
5. Have you been diagnosed by a licensed member of the medical profession as having AIDS (Acquired Immunodefiency Syndrome) or HIV (Human Immunodeficiency Virus)? If Yes, please provide details.	☐ Yes	☐ No
6. Have you ever been advised by a licensed medical professional to reduce or discontinue the use of alcohol or drugs?	☐ Yes	☐ No
7. Other than as noted above, have you ever been counseled or treated because of alcohol, controlled substance or drug use?	☐ Yes	☐ No
8. Have you ever used narcotics, amphetamines, barbiturates, heroin, cocaine, marijuana, or other habit-forming drugs, except as prescribed by a licensed medical professional?	☐ Yes	☐ No
9. OTHER THAN AS PREVIOUSLY DESCRIBED, IN THE PAST 5 YEARS HAVE YOU:		
a. Consulted with a licenced member of the medical profession, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed (except HIV)?	☐ Yes	☐ No
b. Been an inpatient or outpatient in a hospital, clinic, medical or mental health facility?	☐ Yes	☐ No
c. Had any electrocardiograms, x-rays, blood studies, scans, or other diagnostic tests (except HIV)?	☐ Yes	☐ No
10. Are you presently taking any medication(s), including nonprescription/over-the-counter medication or supplements? If Yes, list all medications and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over-the-counter drugs, aspirin and herbal supplements in the remark section.	☐ Yes	☐ No
11. Have you ever used any nicotine or tobacco products?	☐ Yes	☐ No
If Yes, indicate Type of Product _____ Date of Last Use m m y y y y		

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REMARKS: Complete this section if you answered "Yes" to any of the questions on the previous page. If you need additional space, attach a separate piece of paper to this application with the proposed insured's signature and date.

Question No. and Letter	Name and Address of Health Professional	Date/Duration of Illness	Diagnosis/Treatment/Medication

Section C: Family History (Please provide details in the chart below.)

1. Have your natural parents or siblings ever been diagnosed or treated by a licensed member of the medical profession for: heart or vascular disease, stroke,cerebrovascular disease, diabetes, cancer, or kidney disease? If "Yes," please provide details in the table below. ☐ Yes ☐ No

Relationship to Proposed Insured	Age of Onset	Age if Living	Age at Death	State of Health (Specific Conditions) or Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				

Agreement

I, the Proposed Insured, have read the above answers and statements and they: (a) are true and complete to the best of my knowledge and belief and (b) were correctly recorded before I signed this LIFE INSURANCE APPLICATION – PART II. These answers, together with those provided in Part I of the Application and any additional supplements to this application constitutes the entire Application, which will be attached to and made a part of the issued policy. I understand TIAA-CREF Life Insurance Company will rely upon the information provided in the Application to determine whether it will issue the life insurance policy applied for in this Application.

Fraud Warning
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X_____ _____
Signature of Proposed Insured | Signed at (City, State) | Date

X_____ _____
Signature of Witness | Relationship | Date

Section D: EXAMINATION (TO BE COMPLETED BY EXAMINER)

The questions which appear below are intended only as a basis for the examination. TIAA-CREF Life Insurance Company relies on its examiners to observe and report all information collected during the examination.

1. a. Height (in shoes) _____ ft. _____ in. b. Weight (clothed) _____ lbs.

c. Did you weigh the proposed insured? ☐ Yes ☐ No

If No, please explain. _____

2. Blood Pressure	Initial Reading	2nd Reading	3rd Reading
	Systolic _____	Systolic _____	Systolic _____
	Diastolic _____	Diastolic _____	Diastolic _____

3. Pulse at Rest _____

Describe any irregularities _____ Number of irregularities per minute _____

4. Are blood and urine specimens being collected and mailed to the lab?	☐ Yes	☐ No
Indicate Name of Lab _____		
5. Does the Proposed Insured appear unhealthy or older than stated age? If Yes, please explain. If Yes, please explain. _____	☐ Yes	☐ No
6. How long have you known the Proposed Insured? _____		
7. Are you related to the Proposed Insured or the agent?	☐ Yes	☐ No
8. Are you the Proposed Insured's Primary Care Physician?	☐ Yes	☐ No
9. Was the examination conducted in a language other than English?	☐ Yes	☐ No

If Yes, indicate language used and provide name and relation to person acting as interpreter.

Language Used _____

Name of Interpreter _____ Relation to Proposed Insured _____

10. Which Government Issued Picture ID did you verify (Photo Identification required)? Provide the ID number below.

☐ Driver License No. _____ ☐ ID Card _____

☐ Passport _____ ☐ Other (Type) _____

REMARKS

Section D: EXAMINATION (CONTINUED)

ADDITIONAL REMARKS

Medical Examiner's Certification

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

Examined at _____, this _____ day of _____, 20_____, at _____ am/pm

Examiner's Name _____ Type of License _____
Please Print

Examiner's Signature X _____ Examiner's Telephone No. - -

Examiner's SSN/TIN

Name of Paramedical Company	City	State

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