INDIVIDUAL LIFE INSURANCE APPLICATION

Has an application or informal inquiry ever been made to Pinnacle Life for annuity, life, long-term care or disability insurance on the life of the insured?..... ☐ Yes ☑ No If "Yes," the last policy number related to that application or inquiry is:

☐ Companion Policy

1. INSURED

A. LEGAL NAME	FIRST	M.I.	LAST *(Include maiden name in parentheses.)*	LINEAGE *(e.g., Sr., Jr.)*
Wilson	Thomas	R	Wilson	☑ Male ☐ Female

B. BIRTHDATE *(MM/DD/YYYY)*	C. STATE OF BIRTH *(or Foreign Country)*	D. TAXPAYER ID NUMBER
05/12/1976	California	123-45-6789

E. ADDRESS OF PRIMARY RESIDENCE	CITY	STATE	ZIP CODE
742 Evergreen Terrace	Springfield	IL	62704

F. PHONE NUMBER: ☑ Home ☐ Business Mobile? ☑ Yes ☐ No	G. E-MAIL ADDRESS
555-123-4567	thomas.wilson@example.com

2. APPLICANT

Select ONLY ONE: ☑ Insured at Insured's Address OR ☐ Other *(Complete A-J)*

A. LEGAL NAME	FIRST	M.I.	LAST	LINEAGE *(e.g., Sr., Jr.)*
Wilson	Thomas	R	Wilson	☑ Male ☐ Female

OR BUSINESS NAME/TRUST NAME

B. TYPE OF BUSINESS/TRUST
☐ Corporation(If Bank FDIC #_____) ☐ Partnership ☐ Revocable or ☐ Irrevocable Trust Type of Trust: ☐ Personal ☐ Business
☐ Other Type of Business

C. TRUST DATE *(MM/DD/YYYY) (If applicable)*	D. NAME OF TRUSTEE(S) *(If applicable)*

E. RELATIONSHIP TO INSURED	F. BIRTHDATE *(MM/DD/YYYY) (If applicable)*	G. TAXPAYER ID NUMBER
Self	05/12/1976	639-05-8901

H. MAILING ADDRESS ☑ Insured's Address	CITY	STATE	ZIP CODE
	Springfield	IL	62704

I. PHONE NUMBER: ☑ Home ☐ Business Mobile? ☑ Yes ☐ No	J. E-MAIL ADDRESS
555-123-4567	thomas.wilson@example.com

3. OWNER - Note: A minor Owner cannot exercise policy rights until reaching legal age. Complete Personal or Business/Trust Information.

Select ONLY ONE: ☑ Insured *(Complete E)* ☐ Applicant *(Complete E)* ☐ Other *(Complete Personal or Business/Trust)* OR
☐ See attached Owner form/letter

PERSONAL

A. LEGAL NAME	FIRST	M.I.	LAST	LINEAGE *(e.g., Sr., Jr.)*
Wilson	Thomas	R	Wilson	☑ Male ☐ Female

B. RELATIONSHIP TO INSURED	C. BIRTHDATE *(MM/DD/YYYY)*	D. TAXPAYER ID NUMBER
Self	05/12/1976	123-45-6789

E. MAILING ADDRESS ☑ Insured's Address ☐ Applicant's Address OR	CITY	STATE	ZIP CODE
	Springfield	IL	62704

F. PHONE NUMBER: ☑ Home ☐ Business Mobile? ☑ Yes ☐ No 555-123-4567		**G. E-MAIL ADDRESS** thomas.wilson@example.com		
BUSINESS/TRUST				
H. BUSINESS NAME/TRUST NAME				
I. TYPE OF BUSINESS/TRUST ☐ Corporation(If Bank FDIC #_____) ☐ Partnership ☐ Revocable or ☐ Irrevocable Trust Type of Trust: ☐ Personal ☐ Business ☐ Other Type of Business				
J. TAXPAYER ID NUMBER	**K. TRUST DATE** ***(MM/DD/YYYY) (If applicable)***	**L. NAME OF TRUSTEE(S)** ***(If applicable)***		
M. MAILING ADDRESS		**CITY**	**STATE**	**ZIP CODE**
N. PHONE NUMBER: ☐ Home ☐ Business Mobile? ☐ Yes ☐ No		**O. E-MAIL ADDRESS**		

4. SUCCESSOR OWNER - Complete this section when the Owner named above is an individual who is not the Insured. If a Successor Owner is not named in the designated section below, the Successor Owner will be the Insured. Note: A minor Owner cannot exercise policy rights until reaching legal age.

A. ☐ If the Owner dies before the Insured, the Successor Owner will be *(NAME)* _____,

(RELATIONSHIP TO INSURED) _____. If both the Owner and Successor Owner die before the Insured, the Insured will become the Owner.

B. ☐ The Insured will become the Owner upon attaining the age of _____ years. If the Owner dies before the Insured attains such age the Successor Owner will be *(NAME)*_____, *(RELATIONSHIP TO INSURED)*_____.
Upon the Insured attaining such age or, if both the Owner and Successor Owner die before the Insured, the Insured will become the Owner.

5. PREMIUM PAYER

Select ONLY ONE: ☑ Insured *(Complete F)* ☐ Applicant *(Complete F)* ☐ Owner *(Complete F)* OR ☐ Other *(Complete A-H)*

A. LEGAL NAME	**FIRST**	**M.I.**	**LAST**	**LINEAGE** *(e.g., Sr., Jr.)*
Wilson	Thomas	R	Wilson	☑ Male ☐ Female

OR BUSINESS NAME

B. TYPE OF BUSINESS
☐ Corporation (If Bank FDIC # _____) ☐ Partnership ☐ Other type of Business _____

C. RELATIONSHIP TO INSURED	**D. BIRTHDATE** ***(MM/DD/YYYY) (if applicable)***	**E. TAXPAYER ID NUMBER**	
Self	05/12/1976	123-45-6789	
F. MAILING ADDRESS ☑ Insured's ☐ Applicant's ☐ Owner's OR	**CITY** Springfield	**STATE** IL	**ZIP CODE** 62704
G. PHONE NUMBER: ☑ Home ☐ Business Mobile? ☑ Yes ☐ No 555-123-4567	**H. E-MAIL ADDRESS** thomas.wilson@example.com		

6. PREMIUM

☑ Prepaid Premium Payment - Initial Premium Paid: $ 37.63 OR ☐ Non Prepaid

7. TEMPORARY LIFE INSURANCE AGREEMENT

Has the premium for the policy(ies) applied for been given to the agent in exchange for the Temporary Life Insurance Agreement?..... ☑ Yes ☐ No

Note: A Temporary Life Insurance Agreement should not be provided when the Applicant is only exercising an Additional Purchase Benefit with no underwritten increase.

8. POLICY INFORMATION - Submit one Application Supplement for each policy applied for.

A. Number of *Application Supplements* being submitted: 1

B. One option below must be selected: ***(Not applicable for Universal Life or Term insurance.)***
☑ Do not activate the Automatic Premium Loan provision *(Policy will default to Extended Term insurance.)*
☐ Activate the Automatic Premium Loan provision

Note: Submit a complete NAIC Basic Illustration (all pages, signed and dated) OR, if no illustration conforming to the policy applied for was shown to the Applicant, check the Illustration Certification box (page 7). *(Not applicable for Variable Life.)*

10. COMPLETE IF INSURED IS DEPENDENT ON ANOTHER PERSON FOR FINANCIAL SUPPORT

A. Name of supporting person and relationship to Insured: Emily Wilson (Spouse)

B. Amount of life insurance on supporting person's life payable to Insured: $ 500,000

C. If Insured is under age 21:

NAME(S)	AGE(S)	LIFE INSURANCE INFORCE AND PENDING	ANNUAL EARNED INCOME
Father	65	$ 250,000	$ 75,000
Mother	63	$ 200,000	$ 65,000
Brothers	39, 35	$ 300,000	
Sisters	41	$ 250,000	

D. If Applicant is grandparent, grandparent's net worth: $ N/A

11. ANNUAL SALES INVENTORY (Complete this section.)

A. Complete if insured is 18 or older.

1. Insured's Education: ☐ High School or less (1) ☐ Some College (2) ☑ College Graduate (3) ☐ Graduate Degree (4)

2. Total Number of Children: ☐ None 2

3. Age of Children, if any: ☐ All Under 3 (1) ☐ All Under 6 (2) ☐ All Under 12 (3) ☑ All Under 18 (4) ☐ Some or all 18 or over (5)

4. Annual Premiums: Excluding this application, what is the Insured's approximate total annual cash outlay for insurance on his or her life in all companies
$ ☑ None

B. Complete for all Insured's:

1. Source of Applicant:
☑ FR's Own Policyowner (10) ☐ CRC Client (11) ☐ Referred Lead (12) ☐ Acquaintance (13)
☐ Newcomer Service (14) ☐ Cold Canvas (15) ☐ Lead Letter Reply (16) ☐ Published Sources (17)
☐ Walk in (18) ☐ Family Member (19) ☐ FR's Network Client (20) ☐ Other (specify) (29)

2. Primary Purpose
Personal: ☑ Total Needs (10) ☐ Education (11) ☐ Income Replacement (12) ☐ Savings (13) ☐ Debt Coverage (17) ☐ Other (19)
Business: ☐ Keyperson (20) ☐ Business Purchase (21) ☐ Debt Coverage (22)
Executive Benefits - Business Owner: ☐ Deferred Comp (24) ☐ SERP (26) ☐ Split Dollar (27) ☐ Death Benefit Only (28) ☐ Other (29)
Executive Benefits Non-Business Owner: ☐ Split Dollar (70) ☐ Bonus (71) ☐ Deferred Comp (72) ☐ SERP (73) ☐ Death Benefit Only (74) ☐ Other (75)
Estate: ☐ Estate Liquidity (37) ☐ Charitable Gift (38) ☐ Other (39)

3. Basic Sales Presentation
☐ TPPA (10) ☐ BPA (11) ☐ Multiples of Salary (13)
☐ Outside Software (15) ☑ Insurance & Savings (21) ☐ Life Presentation (23)
☐ Business Presentation (26) ☐ Executive Benefits (27) ☐ FR's Own Materials (33)
☐ Competitive Reports (34) ☐ NM Print Materials (35) ☐ Other (39)

12. INSURED'S RELATIONSHIP TO FINANCIAL REPRESENTATIVE

☐ Related to Financial Representative - Relationship ☑ Financial Representative ☐ Existing Relationship ☐ Not Previously Known

13. PRODUCTION AND COMMISSION CREDITS

Exclude this policy from Commission Authorization (CA) review? Note: If this question is not answered, the application will be reviewed for a CA... ☐ Yes ☑ No

FR'S NO. (SERVICING FR FIRST)	FINANCIAL REPRESENTATIVE'S FULL NAME	% INTEREST	CONTRACT TYPE PRIMARY(1) OR SECONDARY(2) (P OR S)	IF CONTRACT TYPE "S" ENTER SECONDARY FR NUMBER
62485	Michael Anderson	100	P	

NETWORK OFFICE NO.	FR'S TELEPHONE NUMBER	SET TEAM / Name of Associate FR or FRs Assistant:	TELEPHONE NUMBER

054	555-789-0123	Jennifer Parker	555-789-0124

(1) Primary Contract Type- If the application is the result of doing business in your state of residence through the Network Office with whom you hold your primary contract (i.e., do the majority of your business).
(2) Secondary Contract Type- If the application is the result of doing business through a Network Office with whom you hold a secondary contract (i.e., through whom you conduct a considerably smaller amount of business, such as in a state where you have a vacation residence).

I certify the following: (1) the Company has been provided with all information required by the Company's policies; (2) the questions on this Application have been asked as required by the application process; (3) all answers have been accurately and completely recorded; and (4) neither I nor anyone who participated in the completion of the application knows anything unfavorable about the Insured or any other party that is not stated in the application or accompanying letter. I further certify that I understand, and have followed the information stated on LINKnet - Completing Applications (in person or remotely):

I and anyone who participated in the completion of this Application have completed all required home office training and state mandated continuing education for this sale of product(s). The Insured and Owner if other than the Insured, has been given a copy of the Notice of Insurance Information Practices, as required by the Fair Credit Reporting Act and state regulations. The Owner, if other than the Insured, has been given a copy of the Employer Owner Life Insurance Disclosure Statement.

A. Did you or your staff meet face-to-face with the Insured (or Guardian) to complete this application?..... ☐ Yes ☑ No

B. If "No," have you or your staff met face-to-face with the Insured (or Guardian) in the last two years to discuss their financial needs?..... ☑ Yes ☐ No

C. Has a member of your staff been the primary person making this sale?..... ☑ Yes ☐ No

If "Yes," he/she should sign and enter his/her name and field staff number below:

James Reynolds	JR73921	*James Reynolds*
Name of LICENSED AGENT/FIELD STAFF (Please print)	AGENT/FIELD STAFF#	Signature of LICENSED AGENT/FIELD STAFF

MEDICAL HISTORY QUESTIONNAIRE

INSURED NAME	FIRST	M.I.	LAST
	Thomas	R	Wilson

Instructions:

- As used in this Medical History Questionnaire, the terms "you" and "your" refer to the Insured. The terms "you" and "the Insured" are used interchangeably throughout.
- Each question must be individually asked and answered. Use the DETAILS section or Additional Details page to explain all checked boxes (other than "NONE") and all "YES" responses.

To begin the Medical History Questionnaire, read the 'Declaration of Truth' with the Insured or Parent/Guardian. They must "Agree" to proceed.

Declaration of Truth: *The responses provided below are complete, accurate, and truthful to the best of my knowledge and belief. I acknowledge that any inaccurate or misleading statements could result in the reformation, rescission or termination of this policy and impact the payment of future claims. Given false information to an insurance company, plus as a mutual company, inaccurate or misleading statements potentially harm other policyholders.*

☑ Agree

HEALTHCARE PROVIDERS

1. Do you have a regular physician, doctor or healthcare provider?..... ☑ YES ☐ NO

If "YES," complete the information below on your current physician, doctor or healthcare provider:

NAME	TELEPHONE NUMBER		
Dr. Elizabeth Morgan	555-456-7890		
ADDRESS 123 Medical Plaza, Suite 302	CITY Springfield	STATE IL	ZIP CODE 62704
WHEN DID YOU LAST SEE THIS MEDICAL PROVIDER? (MM/YYYY) March 2020	REASON FOR YOUR LAST VISIT? Physical & Labs - all normal		

2. Have you been receiving care from your regular physician, doctor or healthcare provider for less than two years?..... ☐ YES ☑ NO

If "YES," complete the information below on your former physician, doctor or healthcare provider:

NAME	TELEPHONE NUMBER		
ADDRESS	CITY	STATE	ZIP CODE
WHEN DID YOU LAST SEE THIS MEDICAL PROVIDER? (MM/YYYY)	REASON FOR YOUR LAST VISIT?		

GENERAL INFORMATION

3. Is the Insured over age 5? If "YES," complete A-C below..... ☑ YES ☐ NO

A. Height: 6 ft. 2 in.

B. Weight: 231 lbs.

C. Have you lost more than 10 pounds in the last 6 months?..... ☐ YES ☑ NO

If "YES," how many pounds have you lost?
Provide details about the weight change (e.g., intentional through diet and exercise):

4. Are you pregnant? (Females only)..... N / A ☐ YES ☐ NO

If "YES," what is your due date? _____ (MM/YYYY)

JUVENILE HEALTH

5. Is insured age 5 or under? If "YES," complete A-F below..... ☐ YES ☑ NO

A. Height: _____ ft. _____ in.

B. Weight: _____ lbs. _____ oz.

C. Was the insured born prematurely (gestational age <37 weeks)?..... ☐ YES ☐ NO

If "YES," what was the Insured's gestational age (in weeks) at birth _____

D. Has the insured been evaluated, tested, diagnosed with, or treated for developmental delay(s) by ☐ YES ☐ NO

a medical provider? If "YES," describe the delay(s): _____

E. Has the insured been diagnosed with any growth concerns (including length/height, weight, and

head circumference) or failure to thrive (FTT) by a medical provider?..... ☐ YES ☐ NO

If "YES," provide birth length and weight: Length: _____ ft. _____ in. Weight: _____ lbs. _____ oz.

If "YES" for D and/or E, who was the medical provider seen for this condition (if different than the insured's regular

physician):

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

When did you last see this medical provider? _____ (MM/YYYY)

F. Check any of the services the Insured has received or been advised to receive by a medical provider, and if applicable,

provide the date service was last received:

☐ N/A ☐ Educational services _____ (MM/YYYY) ☐ Occupational therapy _____ (MM/YYYY)

☐ Physical therapy _____ (MM/YYYY) ☐ Speech/Language therapy _____ (MM/YYYY)

DISEASES AND DISORDERS

For each of the categories of Diseases and Disorders throughout question 6, check each box accordingly or check "None."

Provide detail for each condition in the "Details" box provided or use the Additional Details page.

6. In the past 10 years, have you been told you had, been diagnosed with, or treated for any of the following by a

medical provider:

CARDIOVASCULAR

☑ Aneurysm
☑ Angina
☑ Cardiac bypass surgery
☑ Cardiac stent(s)
☑ Chest Pain/Tightness/Discomfort
☐ Coronary artery disease
☐ Heart attack
☐ Heart failure
☐ Heart murmur
☐ Heart valve disorder
☐ High blood pressure
☐ High cholesterol
☐ Irregular heart beat or heart rhythm disorder
☐ Stroke
☐ Transient Ischemic Attack (TIA)
☐ Any other diseases or disorders of the heart or blood vessels

☑ NONE

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis		

		Evaluations, Tests, Treatments and General Information **(e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)**	**Physician Information** **Name, complete address, and telephone numbers of medical providers.**

CANCER/GROWTHS

- [ ] Cancer
- [x] Lymphoma
- [ ] Polyps
- [ ] Cysts
- [ ] Masses
- [ ] Tumors
- [ ] Leukemia
- [ ] Nodules
- [ ] NONE

RESPIRATORY

- [ ] Asthma
- [ ] Emphysema
- [ ] Throat disorder
- [ ] Chronic cough
- [ ] Sinus disorder
- [ ] Trouble breathing
- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Sleep apnea
- [ ] Any other diseases or disorders of the lungs or respiratory system
- [ ] Sleep disorder other than sleep apnea
- [x] NONE

NEUROLOGY

- [ ] Carpal tunnel syndrome
- [ ] Loss of consciousness
- [ ] Paralysis
- [ ] Concussion
- [ ] Memory loss or memory impairment
- [ ] Seizure/Epilepsy
- [ ] Difficulty walking
- [ ] Multiple sclerosis
- [ ] Tremor
- [ ] Dizziness
- [ ] Muscle weakness
- [ ] Vertigo
- [ ] Headaches
- [ ] Neuropathy
- [ ] Any other diseases or disorders of the brain or nervous system
- [ ] Imbalance
- [x] NONE

PSYCHIATRIC/MENTAL HEALTH

- [ ] Anxiety
- [ ] Depression
- [ ] Stress
- [ ] Attention deficit/Hyperactivity Disorder (ADD or ADHD)
- [ ] Eating disorder
- [ ] Any other diseases or disorders of psychiatric or mental health
- [ ] Bipolar disorder
- [ ] Post traumatic stress disorder (PTSD)
- [x] NONE

GASTROINTESTINAL (GI)

- [ ] Barrett's Esophagus
- [ ] Pancreatitis
- [ ] Ulcerative colitis
- [ ] Blood in the stool
- [ ] Recurrent heartburn/GERD (Gastroesophageal Reflux Disease)
- [ ] Ulcers
- [ ] Crohn's disease
- [ ] Recurrent or persistent abdominal pain
- [ ] Any other diseases or disorders of the esophagus, stomach, intestines, liver, gallbladder or pancreas
- [ ] Difficulty swallowing
- [ ] Recurrent or persistent diarrhea
- [ ] Hepatitis
- [ ] Recurrent or persistent vomiting
- [ ] Irritable bowel syndrome (IBS)
- [x] NONE

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis	Evaluations, Tests, Treatments and General Information (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	Physician Information Name, complete address, and telephone numbers of medical providers.
Lymphoma	02/2019	Had chemotherapy, resolved May 2019.	Dr. Robert Stevens Memorial Cancer Center 450 Oncology Drive Springfield, IL 62704 555-789-4321

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ENDOCRINOLOGY/GLANDULAR

- [ ] Adrenal disorder
- [ ] Diabetes or elevated blood glucose
- [x] NONE
- [ ] Pituitary disorder
- [ ] Thyroid disorder
- [ ] Any other diseases or disorders of the endocrine/glandular system

HEMATOLOGY/IMMUNOLOGY - ALSO ADDENDUM H, FOR ICC STATES

- [ ] Allergies
- [ ] Anemia
- [ ] Bleeding disorder
- [x] NONE
- [ ] Clotting disorder
- [ ] Enlarged lymph nodes
- [ ] Recurrent Infection
- [ ] Any other diseases or disorders of the blood, bone marrow or immune system, excluding HIV or AIDS

RHEUMATOLOGY

- [ ] Amputation
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Osteoporosis
- [ ] Systemic lupus
- [x] NONE
- [ ] Any disease or disorder of the mouth or jaw
- [ ] Any other disease or disorder of the muscles, bones, joints (including but not limited to the hips, knees, shoulders)
- [ ] Any other diseases or disorders of the spine, neck, back, or extremities

GENITOURINARY

- [ ] Blood in the urine
- [ ] Chronic kidney disease
- [ ] Infertility
- [ ] Kidney infection
- [x] NONE
- [ ] Kidney stones
- [ ] Protein in the urine
- [ ] Sexually transmitted diseases, e.g., chlamydia
- [ ] Any other diseases or disorders of the kidneys, urinary tract, bladder, prostate, reproductive organs, or breasts

DERMATOLOGY

- [ ] Basal cell cancer
- [ ] Dermatitis
- [ ] Eczema
- [x] NONE
- [ ] Melanoma
- [ ] Psoriasis
- [ ] Squamous cell cancer
- [ ] Any other diseases or disorders of the skin

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis	Evaluations, Tests, Treatments and General Information (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	Physician Information Name, complete address, and telephone numbers of medical providers.

[redacted]

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OTHER DISEASES OR DISORDERS

- ☐ Chronic fatigue (present 3 months or longer)
- ☐ Chronic Lyme disease (present 3 months or longer)
- ☑ NONE
- ☐ Chronic pain (present 3 months or longer)
- ☐ Ears
- ☐ Eyes
- ☐ Nose
- ☐ Speech

DETAILS: Complete for each checked box above. If more space is required, use Additional Details page.

Disease/ Condition	Date of Diagnosis	Evaluations, Tests, Treatments and General Information (e.g., details and results, dates or frequency of service and care, time since last symptoms and time since recovery)	Physician Information Name, complete address, and telephone numbers of medical providers.

7. In the past 10 years, have you ever tested positive for human immunodeficiency virus (HIV), or been diagnosed by a medical provider as being HIV positive, or having acquired immune deficiency syndrome..... ☐ YES ☑ NO

If "YES," provide details: _____

TOBACCO, ALCOHOL AND DRUGS

8. When was the last time you used tobacco or any other nicotine products?

Check the box for any products used.	Date Last Used (MM/YYYY)	Frequency Used Per Year	Never Used
☐ Cigarettes			☑
☐ Cigars			☑
☐ Chew or Snuff			☑
☐ Pipes			☑
☐ Vaping Products			☑
☐ Nicotine Patch			☑
☐ Nicotine Gum			☑
☐ Other			☑

9. In the past 10 years, have you ever been advised by a medical provider to reduce or discontinue the use of alcohol? If "YES," complete A-B below..... ☐ YES ☑ NO

A. How many drinks, on average, do you consume in a given week?

☐ 0 ☑ 1-14 ☐ 15-21 ☐ 22-28 ☐ 29-35 ☐ 36-42 ☐ 43-49 ☐ 50 or more

B. When did you last drink alcohol? 01/2021 (MM/YYYY)

[redacted]

10. In the past 10 years, have you ever received or been advised by a medical provider to seek treatment, counseling or participation in a support group for the use of alcohol or drugs?..... ☐ YES ☑ NO

If "YES," complete A-F below:

A. Was this related to alcohol and/or drug use? ☐ Alcohol ☐ Drugs

B. If drug use, list all types of drugs used: _____

C. When did you last drink alcohol? _____ (MM/YYYY) ☐ N/A

D. When did you last use drugs? _____ (MM/YYYY) ☐ N/A

E. Indicate if you have received inpatient or outpatient treatment along with duration of care: ☐ N/A

☐ Inpatient _____ (MM/YYYY) to _____ (MM/YYYY)

☐ Outpatient _____ (MM/YYYY) to _____ (MM/YYYY)

F. Medical providers, counsellors or facilities seen related to your treatment/counselling:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

When did you last see this medical provider? _____ (MM/YYYY)

11. In the past 5 years, have you used marijuana? If "YES," complete A-G below..... ☑ YES ☐ NO

A. Indicate the frequency of your use:

☐ Daily ☑ Weekly ☐ Monthly ☐ Annually

B. How many days per: ☑ Week ☐ Month ☐ Year do you use marijuana? 2 (during treatment)

C. When did you last use marijuana? 02/2020 (MM/YYYY) Recommended by

D. Is your marijuana use: ☐ Recreational ☑ Medical ☐ Both see page 3.

E. Provide the medical reason for your medical marijuana use: Lymphoma, helped with side effects

F. Check all boxes that apply concerning the methods that you used or consumed marijuana:

☑ Smoking ☐ Vaporizing ☑ Edible Forms ☐ Other pharmaceutical forms (e.g., pills, oil)

G. Provide name of medical provider (if different from your regular physician) who prescribed medical marijuana:

Name: Not prescribed by recommended (See pg. 3)

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

When did you last see this medical provider? 11/2020 (MM/YYYY)

12. In the past 10 years, have you used cocaine, heroin, methamphetamine, hallucinogens, or any other illegal drugs or substance? If "YES," complete A-B below..... ☐ YES ☑ NO

A. Provide details of all illegal drugs/substances used: _____

B. When did you last use any of the listed drugs or substances? _____ (MM/YYYY)

13. In the past 5 years, have you used narcotics/opioids, sedatives, amphetamines, or any other controlled substance other than as prescribed by a physician or in excess of dosages prescribed by a physician? If "YES," complete A-B below..... ☐ YES ☑ NO

A. Provide medications or controlled substances used: _____

B. When did you last use any of the listed medications or controlled substances? _____ (MM/YYYY)

[redacted] [redacted] [redacted]

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HEALTHCARE HISTORY

14. In the past 5 years, other than as previously stated on the application, have you:
If "YES," to questions A-D, provide details below:

A. Consulted any other medical providers (medical doctors, psychiatrists, psychologists, counselors/therapists, chiropractors, naturopaths, occupational/physical/speech therapists or other healthcare providers)?..... ☐ YES ☑ NO

B. Been a patient in a hospital, clinic, rehabilitation center, or any other medical facility?..... ☐ YES ☑ NO

C. Had any diagnostic or screening tests completed (e.g., EKGs, x-rays, blood tests, CT scans, MRI scans, heart scans, biopsies, or other tests except for Human Immunodeficiency Virus (HIV)?..... ☑ YES ☐ NO

D. Had surgery?..... ☐ YES ☑ NO

DETAILS: Complete for each "YES" answer above. If more space is required, use Additional Details page.

Reason for Consultation, Hospitalization, Surgery or Testing	Dates of Care or Hospitalization	Evaluations, Tests, Treatments (e.g., details and results of testing or surgery, dates or duration of care)	Physician Information Name, complete address, and telephone number of medical providers.
14c. EKG	08/2019	Normal, done to make sure ok to start chemotherapy	all done by
X-ray - chest	02/2019	found enlarged lymph node - lymphoma related	see pg. 3 - same med for contact info.
CT of chest	02/2019	also showed enlarged lymph nodes (lymphoma related)	

E. Been advised by a medical provider to have any test, consultation, hospitalization, or surgery that was not completed (except as related to the Human Immunodeficiency Virus (HIV)?..... ☐ YES ☑ NO

If "YES," provide details of what was recommended and why the recommendation(s) was not completed:

_____

15. Other than as previously stated on this application, are you taking any medications or drugs (legal or illegal; prescription or non-prescription/over-the-counter or supplements) for any reason?..... ☑ YES ☐ NO

If "YES," list the medication(s)/drug(s) and the reason(s) for use: Claritin - seasonal allergies

16. A. During the past 6 months, have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury?..... ☐ YES ☑ NO

If "YES," complete 1-4 below:

1. Describe the medical issue(s)/condition(s) that resulted in the work absence or modified work schedule:

_____

2. Describe the extent and duration of the modified work schedule or absence:

_____

3. Have you resumed working your previous schedule and duties? ☐ YES ☐ NO

If "YES," provide date of return: _____ (MM/YYYY)

4. Medical provider seen for this issue (if other than your regular physician):

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

When did you last see this medical provider? _____ (MM/YYYY)

[redacted] [redacted] [redacted]

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B. In the past 5 years, have you requested or received payments, benefits, or a pension because of any injury, accident, sickness, disability, or impairing condition?..... ☐ YES ☑ NO

If "YES," complete 1-4 below:

1. Describe the medical issue(s) that resulted in the payment or request for payment:

_____

2. What type of payment was requested and/or received:

☐ Individual Disability ☐ Group Disability ☐ Social Security Disability ☐ Worker's Compensation
☐ Military Pension ☐ Other _____

3. Are you still receiving a payment? ☐ YES ☐ NO

If "YES," what is the duration of payment (in years)? _____

If "NO," are you still pursuing a payment? ☐ YES ☐ NO

4. Medical provider seen for this issue (if other than your regular physician):

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

When did you last see this medical provider? _____ (MM/YYYY)

FAMILY HEALTH HISTORY

17. A. Do you have any immediate family members (including any living or deceased parents and siblings) who were diagnosed or treated by any medical provider for heart disease, stroke, diabetes, kidney disease, cancer (e.g., melanoma, breast cancer, or other cancers), mental illness, dementia, Huntington's disease, neurofibromatosis, or aneurysm(s)?..... ☐ YES ☑ NO

B. List any tests below that you may have had to evaluate your risk based on your family history: ☑ N/A

_____

_____

C. Provide the following information about your immediate family members, including any conditions from 17A.

FAMILY MEMBER	CURRENT AGE (IF LIVING)	MEDICAL CONDITIONS	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Father	67	high blood pressure	60+		
Mother	63	none known			
Sister(s)	35	none known			
Brother(s)	18				

SIGNATURE(S)

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.

I have reviewed my answers and statements in this application and declare that they are correctly recorded, complete and true to the best of my knowledge and belief. Statements in this application are representations and not warranties.

Thomas R. Wilson
Signature of:

☐ LICENSED AGENT/FIELD STAFF - non-exam ☑ PARAMEDICAL EXAMINER - paramedical exam

[redacted] [redacted] [redacted]

ADDITIONAL DETAILS

MEDICAL HISTORY QUESTIONNAIRE

INSURED NAME	FIRST	M.I.	LAST
	Thomas	R	Wilson

Use for any explanation where additional space is required.

Diseases/Disorders or Question #	Details

I have reviewed my answers and statements on this Supplement and declare that they are correctly recorded, complete and true to the best of my knowledge and belief. Statements in this Supplement are representations and not warranties. This Supplement shall be attached and made part of the application.

Thomas R. Wilson
Signature of:

JR73921
AGENT/FIELD STAFF #

James Reynolds
Name of LICENSED AGENT/FIELD STAFF (Please print)

☐ LICENSED AGENT/FIELD STAFF - non-exam ☑ PARAMEDICAL EXAMINER - paramedical exam

Fri 01/22/2021 16:53:02

[redacted]

PARAMEDICAL EXAMINATION

INSURED NAME (FIRST, MIDDLE INITIAL, LAST)	INSURED PHONE NUMBER	
[redacted]	[redacted]	☐ FEMALE ☑ MALE

DRIVER'S LICENSE NUMBER	DRIVER'S LICENSE STATE	WAS A PICTURE ID SHOWN FOR VERIFICATION? ☑ YES ☐ NO	SOCIAL SECURITY NUMBER [redacted] ONLY RECORD LAST 4 DIGITS
[redacted]	[redacted]		

AMOUNT APPLIED FOR	OCCUPATION
$ 750,000.	[redacted]

1. A. HEIGHT (WITHOUT SHOES, PHYSICALLY MEASURED)	B. WEIGHT (CLOTHED, WITHOUT SHOES) PHYSICALLY WEIGHED
6 FT 2 IN	231 LBS.

2. BLOOD PRESSURE (ANY READING UNDER AGE 18) Take three readings until a valid reading SYSTOLIC/DIASTOLIC	122/80	116/78	114/74	CUFF SIZE ☐ Regular ☑ Large ☐ Other

3. PULSE (RECORD FOR 1 FULL MINUTE)	RATE 70 / MIN	IRREGULARITIES / MIN ☑ NONE ☐ YES - IF YES, # IRREGULARITIES PER MINUTE: _____ / MIN

4. IS THE INSURED CURRENTLY MENSTRUATING?	☐ YES ☑ NO NOTE: If pregnant, please collect blood and urine even if menstruating N/A

5. ARE YOU AWARE OF ANY ADDITIONAL MEDICAL HISTORY OR OTHER FACTS CONCERNING THE INSURED?
☐ YES ☑ NO IF YES, NOTE HERE: _____

6. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE INSURED?
☐ YES ☑ NO IF YES, EXPLAIN: _____

7. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE FINANCIAL REPRESENTATIVE?
☐ YES ☑ NO IF YES, EXPLAIN: _____

8. ARE YOU CONNECTED WITH A NORTHWESTERN MUTUAL NETWORK OFFICE THROUGH EMPLOYMENT, FAMILY RELATIONSHIP OR OTHERWISE?
☐ YES ☑ NO IF YES, EXPLAIN: _____

9. WAS ANY PORTION OF THE EXAMINATION ASKED OR ANSWERED IN A LANGUAGE OTHER THAN ENGLISH? ☐ YES ☑ NO
IF YES:
WHAT PORTION OF THE EXAMINATION WAS TRANSLATED? _____
IN WHAT LANGUAGE WAS IT TRANSLATED? _____
NAME OF INTERPRETER? _____
INTERPRETER'S COMPANY? _____
RELATIONSHIP OF INTERPRETER TO INSURED? _____ ☐ NO RELATIONSHIP
RELATIONSHIP OF INTERPRETER TO FINANCIAL REPRESENTATIVE? _____ ☐ NO RELATIONSHIP

10. PLACE OF EXAMINATION
☑ INSURED'S HOME ☐ INSURED'S PLACE OF BUSINESS ☐ PARAMEDICAL COMPANY BRANCH OFFICE ☐ OTHER (SPECIFY LOCATION)
_____

11. DATE OF EXAMINATION (MM / DD / YYYY)	TIME OF EXAMINATION
01 / 20 / 2021	11:18 ☑ AM ☐ PM

12. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION
[redacted]

13. THE FOLLOWING SPECIMENS HAVE BEEN COLLECTED AND SENT TO THE AUTHORIZED INSURANCE LAB USING KIT: ☑ BLOOD ☑ URINE ☑ SALIVA THE FOLLOWING STUDIES ARE ATTACHED TO THE EXAM OR WILL BE SENT TO THE HOME OFFICE: ☐ RESTING EKG (The insured's name, date of birth and date of the EKG must be printed on the EKG strip. The insured must sign and date the EKG.) ☐ OTHER (Specify) _____	BAR CODE ATTACH BAR CODE HERE FROM LABORATORY CONSENT FORM

I certify that the above is a record of the measurements I completed on the Insured and that I completely and accurately recorded the information and answers to the questions on the [redacted]. I further certify believe the Insured signed it. I certify that I have complied with all instructions on the Paramedical Instructions Page of this exam form.

PARAMEDICAL EXAMINER NAME (PRINT OR STAMP) [redacted]	PHONE NUMBER [redacted]
NAME OF PARAMEDICAL COMPANY (SELECT ONE): ☐ APPS (AMERICAN PARA-PROFESSIONAL SYSTEMS) ☐ EMSI (EXAMINATION MANAGEMENT SERVICES, INC.) ☑ EXAMONE ☐ PORTAMEDIC	
OFFICE ADDRESS [redacted]	CITY/STATE/ZIP CODE [redacted]

[redacted]

Fri 01/22/2021 16:53:02

APPLICANT	:Thomas Wilson	POLICY NUMBER	:ALP48293
DATE OF BIRTH	:05-12-1976	UNDERWRITER	:S Williams
STATE OF RESIDENCE	:IL	REGION	:MW

GENERAL REMARKS: SEE MULTIPLE REMARKS AT THE END OF REPORT

BLOOD CHEMISTRY PROFILE

DATE/TIME LAST MEAL : 01-19-21/11:18 PM DATE PERFORMED : 01-22-21

DATE/TIME DRAWN : 01-20-21/11:18 AM

DETERMINATION	LOW	NORMAL	ELEVATED	USUAL CLINICAL RANGE
GLUCOSE			82 MG/DL	50-99 MG/DL
HEMOGLOBIN A1C			5.5 %	3.0-5.6 %
BUN			12 MG/DL	5-25 MG/DL
CREATININE			1.0 MG/DL	0.5-1.5 MG/DL
ALKALINE PHOSPHATASE			45 U/L	30-115 U/L
BILIRUBIN TOTAL			.5 MG/DL	0.1-1.2 MG/DL
SGOT (AST)			31 U/L	0-41 U/L
SGPT (ALT)* SEE HEPATITIS TESTS *			74 U/L	0-45 U/L
GGT (GGTP)			24 U/L	2-65 U/L
CDT		REFLEX TEST NOT PERFORMED		
TOTAL PROTEIN			6.7 G/DL	6.0-8.5 G/DL
ALBUMIN			4.2 G/DL	3.0-5.5 G/DL
GLOBULIN			1.8 G/DL	1.0-4.0 G/DL
CHOLESTEROL			110 MG/DL	140-200 MG/DL
LDL CHOLESTEROL			45 MG/DL	
HDL CHOLESTEROL			53 MG/DL	>= 40 MG/DL
CHOL/HDL CHOL RATIO			2.1	
TRIGLYCERIDES			63 MG/DL	10-150 MG/DL

HEPATITIS B SURFACE ANTIGEN		NEG
HEPATITIS C ANTIBODY		NEG
HEMOGLOBIN	TEST NOT PERFORMED	13.0-16.0 G/DL
NT_PROBNP	TEST NOT PERFORMED	0-125 PG/ML

SERUM APPEARANCE : NORMAL
REMARKS/BLOOD :

- SPECIAL BLOOD TESTING -

HIV : NON-REACTIVE
REMARKS/HIV :

APPLICANT : Thomas Wilson
POLICY NUMBER : ALP48293
DATE OF BIRTH : 05-12-1976
UNDERWRITER : S Williams
STATE OF RESIDENCE : IL
REGION : MW

GENERAL REMARKS: SEE MULTIPLE REMARKS AT THE END OF REPORT

URINE SPECIMEN RESULTS

DATE/TIME VOIDED : 01-20-21/11:18 AM
DATE PERFORMED : 01-22-21
EXAMINER : EXO

MICROSCOPIC EXAM		**CHEMICAL EXAM**	
WBC :	0/HPF	PROTEIN : 0 MG%	1.022
RBC :	0/HPF	PROTEIN/CREATININE RATIO :	0.00
GRAN. CAST :	0 LPF	MICROALBUMIN :	-- MG%
HYAL. CAST :	0 LPF	MICROALBUMIN/CREATININE RATIO:	--
		GLUCOSE :	.00 GM%

URINALYSIS SPECIAL TESTING :	BETA BLOCKERS	NEG
	NICOTINE	NEG
	COTININE REFLEX	NOT PERFORMED

DRUGS TESTED FOR : COCAINE
DRUGS DETECTED : NO

REMARKS/URINE :
REMARKS/ADULTERANTS : ADULTERANT TESTS WITHIN NORMAL LIMITS

REQUIREMENTS RECEIVED AND DATE REQUESTED

4127	12-29-20
4190	12-29-20

MULTIPLE REMARKS SECTION

GENERAL : REPORT DELAYED DUE TO ADDITIONAL TESTS REQUESTED

GENERAL : ALL TESTS PERFORMED ON BLOOD UNLESS OTHERWISE SPECIFIED.

PHARMACY REPORT - INDIVIDUAL SUMMARY

Name: Thomas Wilson
Policy #: ALP48293
DOB: 05/12/1976
Gender: M
Benefit Eligibility Date
Benefit Termination Date
SSN: XXX-XX-6789
Date Submitted: 12/29/2020

11/01/2020	12/31/2039
11/01/2020	10/31/2020
11/01/2020	10/31/2020
11/01/2020	12/31/2039
11/01/2020	12/31/2020
11/01/2019	12/31/2039
11/01/2019	10/31/2020
11/01/2018	12/31/2039
11/01/2018	12/31/2039
11/01/2018	06/30/2019
11/01/2017	12/31/2039
11/01/2017	10/31/2018
11/01/2017	10/31/2018
10/01/2011	12/31/2039
08/01/2004	12/31/2004
08/01/2004	12/31/2039
07/01/2019	10/31/2019
07/01/2019	12/31/2039
04/01/2016	12/31/2039
04/01/2016	10/31/2017
04/01/2015	03/31/2016
01/01/2003	07/31/2004
01/01/2003	12/31/2039
01/01/2003	12/31/2999
01/01/2003	12/31/2999
01/01/2003	12/31/2999

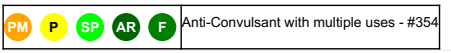
RISK SCORE

Risk Score (Rx): 2.650

IRIX RESULTS


PM
P
SP
AR
F


PM
P
SP
AR
F
Prescription by Oncologist - #360


PM
P
SP
AR
F
Anti-Convulsant with multiple uses - #354

PHARMACY REPORT - INDIVIDUAL SUMMARY

Policy #: [redacted]

PM P SP AR F	Anti-Psychotic used primarily as Anti-Emetic (Prochlorperazine) - Prior - #341
PM P SP AR F	Cholecystolithiasis likely / Primary Biliary Cholangitis possible - Prior - #404
PM P SP AR F	Notes

PHARMACY REPORT - INDIVIDUAL SUMMARY

Policy #: [redacted]

RX SUMMARY HISTORY

[redacted]

RISK	Drug Label & dose-Generic Name	#	First Fill	Last Fill
L	FLUZONE QUADRIVALENT 2019-2020 Influenza Virus Vaccine Split Quadrivalent IM Inj - Influenza Virus Vaccine Split Quadrivalent	1	11/11/2019	11/11/2019

[redacted]

RISK	Drug Label & dose-Generic Name	#	First Fill	Last Fill
M	GABAPENTIN Gabapentin Cap 300 MG - Gabapentin	6	08/27/2019	07/29/2020
M	ALLOPURINOL Allopurinol Tab 300 MG - Allopurinol	1	06/26/2019	06/26/2019
M	ACYCLOVIR Acyclovir Tab 400 MG - Acyclovir	1	06/26/2019	06/26/2019
M	ZOLPIDEM TARTRATE Zolpidem Tartrate Tab 5 MG - Zolpidem Tartrate	1	05/31/2019	05/31/2019
M	TRAMADOL HCL Tramadol HCl Tab 50 MG - Tramadol HCl	3	04/12/2019	06/07/2019
L	LIDOCAINE/PRILOCAINE Lidocaine-Prilocaine Cream 2.5-2.5% - Lidocaine-Prilocaine	2	04/10/2019	04/11/2019
M	ALLOPURINOL Allopurinol Tab 300 MG - Allopurinol	3	04/05/2019	05/30/2019
H	PROCHLORPERAZINE MALEATE Prochlorperazine Maleate Tab 10 MG (Base Equivalent) - Prochlorperazine Maleate	1	04/05/2019	04/05/2019
H	ONDANSETRON HYDROCHLORIDE Ondansetron HCl Tab 8 MG - Ondansetron HCl	1	04/05/2019	04/05/2019
M	ACYCLOVIR Acyclovir Tab 400 MG - Acyclovir	2	04/05/2019	05/19/2019
M	LORAZEPAM Lorazepam Tab 1 MG - Lorazepam	1	03/19/2019	03/19/2019

RISK	Drug Label & dose-Generic Name	#	First Fill	Last Fill
L	AZITHROMYCIN Azithromycin Tab 250 MG - Azithromycin	1	12/04/2018	12/04/2018
L	PROMETHAZINE/CODEINE Promethazine w/ Codeine Syrup 6.25-10 MG/5ML - Promethazine w/ Codeine	2	12/04/2018	01/04/2019
L	MONTELUKAST SODIUM Montelukast Sodium Tab 10 MG (Base Equiv) - Montelukast Sodium	2	01/04/2019	02/14/2019
M	METHYLPREDNISOLONE DOSE PACK Methylprednisolone Tab Therapy Pack 4 MG (21) - Methylprednisolone	1	01/04/2019	01/04/2019

[redacted]

RISK	Drug Label & dose-Generic Name	#	First Fill	Last Fill
M	HYDROCODONE/ACETAMINOPHEN Hydrocodone-Acetaminophen Tab 5-325 MG - Hydrocodone-Acetaminophen	1	10/20/2014	10/20/2014

[redacted]

RISK	Drug Label & dose-Generic Name	#	First Fill	Last Fill
M	OSELTAMIVIR PHOSPHATE Oseltamivir Phosphate Cap 75 MG (Base Equiv) - Oseltamivir Phosphate	1	12/13/2018	12/13/2018
L	MUPIROCIN Mupirocin Oint 2% - Mupirocin	2	06/20/2019	09/17/2019
M	OSELTAMIVIR PHOSPHATE Oseltamivir Phosphate Cap 75 MG (Base Equiv) - Oseltamivir Phosphate	1	02/16/2018	02/16/2018
M	TAMIFLU Oseltamivir Phosphate Cap 75 MG (Base Equiv) - Oseltamivir Phosphate	1	01/16/2014	01/16/2014

PHARMACY REPORT - INDIVIDUAL SUMMARY

Policy #: ALP48293

[redacted]

M	ACETAMINOPHEN/CODEINE PHOSPHATE Acetaminophen w/ Codeine Tab 300-30 MG - Acetaminophen w/ Codeine	1	08/29/2016	08/29/2016

[redacted]

M	AMITRIPTYLINE HYDROCHLORIDE Amitriptyline HCl Tab 10 MG - Amitriptyline HCl	1	03/13/2017	03/13/2017

[redacted]

M	TRAMADOL HCL Tramadol HCl Tab 50 MG - Tramadol HCl	1	02/07/2017	02/07/2017
L	SULFAMETHOXAZOLE/TRIMETHOPRIM DS Sulfamethoxazole-Trimethoprim Tab 800-160 MG - Sulfamethoxazole-Trimethoprim	1	02/02/2017	02/02/2017

[redacted]

L	CORDRAN Flurandrenolide Cream 0.05% - Flurandrenolide	1	02/26/2015	02/26/2015

[redacted]

H	URSODIOL Ursodiol Cap 300 MG - Ursodiol	2	05/13/2019	11/26/2019

[redacted]

L	TRIAMCINOLONE ACETONIDE Triamcinolone Acetonide Oint 0.1% - Triamcinolone Acetonide (Topical)	1	06/22/2018	06/22/2018
L	KETOCONAZOLE Ketoconazole Shampoo 2% - Ketoconazole (Topical)	1	06/19/2018	06/19/2018
L	KETOCONAZOLE Ketoconazole Cream 2% - Ketoconazole (Topical)	1	06/19/2018	06/19/2018

[redacted]

L	CLINDAMYCIN HCL Clindamycin HCl Cap 300 MG - Clindamycin HCl	1	08/24/2016	08/24/2016

[redacted]

M	ACETAMINOPHEN/CODEINE Acetaminophen w/ Codeine Tab 300-30 MG - Acetaminophen w/ Codeine	1	03/07/2019	03/07/2019