Clear Form

ANSWERS MADE TO THE MEDICAL EXAMINER

In continuation of and forming a part of application for insurance to
MOUNTAIN LIFE INSURANCE COMPANY Post Office Box 240 - Alcoa, Tennessee 37701

Proposed Insured _____ Birth Date: _____
First Name Middle Initial Last Name Month Day Year

1. a. Name and address of your personal physician _____
   b. Date and reason last consulted _____
   c. What treatment was given or medication prescribed? _____

		Yes	No
2.	Have you been treated for or had any known indication of:		
a.	Disorder of eyes, ears, nose or throat?	☐	☐
b.	Dizziness, fainting, convulsions, severe or frequent headache, speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c.	Shortness of breath, persistent hoarseness or cough, blood spitting, chronic bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d.	Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e.	Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f.	Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
g.	Diabetes; thyroid or other endocrine disorders?	☐	☐
h.	Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	☐	☐
i.	Deformity, lameness or amputation?	☐	☐
j.	Disorder of skin, breasts, lymph glands; cyst, tumor or cancer?	☐	☐
k.	Allergies; anemia or other disorder of the blood?	☐	☐
3.	Have you had any care or treatment or medical advice for alcohol usage?	☐	☐
4.	Have you used any of the following more than twice: Amphetamines, barbiturates, hallucinogentics, narcotics or marijuana? If prescribed for you by a physician, please explain	☐	☐
5.	Have you smoked cigarettes, cigars, or pipe tobacco within the past 12 months?	☐	☐
6.	Other than above, have you used any other tobacco product in the past 12 months?	☐	☐
7.	Are you now under observation or taking treatment? List medications, with dosage, any special diet within the last 5 years. Give dates	☐	☐
8.	Have you had any change in weight in the past year?	☐	☐
9.	*Other than above*, have you within the past 5 years:		
a.	Had any mental or physical disorder not listed above?	☐	☐
b.	Had a checkup, consultation, illness, injury, surgery?	☐	☐
c.	Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
d.	Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
e.	Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
f.	Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐
g.	Are you taking any medications or drugs?	☐	☐
10.	Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐
11.	Do you participate in regular exercise? If yes, describe type and frequency .	☐	☐

DETAILS of "Yes" answers. **(IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS:** Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers & Sisters No. Living _____ No. Dead _____			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued.

Dated at _____ this _____ day of _____, 20 ____

Witness _____ _____ _____
(Signature of Medical Examiner) Title (Signature of Proposed Insured, or Signature of Parent or Guardian if Proposed Insured is a Minor)

MEDICAL EXAMINER'S REPORT

12. Pulse _____ per/minute ☐ Regular ☐ Irregular
    Number of Irregularities, if any _____

13. Blood Pressure

	1st Reading	2nd Reading	3rd Reading
Systolic	_____	_____	_____
Diastolic	_____	_____	_____

To be taken at separate intervals and if systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest. Then take 2 additional readings.

14. Height _____ (without shoes)

15. Weight _____

16. Did you weigh? ☐ Yes ☐ No

17. Did you measure? ☐ Yes ☐ No

18. Urinalysis (Dipstick)
    a. Glucose _____
    b. Albumin _____

19. Obvious abnormalities:

_____
_____
_____
_____
_____
_____
_____
_____

20. Remarks:

_____
_____
_____
_____
_____
_____
_____
_____

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Medical Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at _____ on _____ 20 _____

Witnessed by _____
Examiner

Signature of Person Examined _____

Examination Branch Address :
(Please print or use stamp)

I certify that I have carefully examined _____

of _____on this _____ day of _____ 20 _____ @ _____ am / pm
Street Address, City

_____ _____
Signature of Examiner Date Address