

**PART II—MEDICAL  
APPLICATION TO THE CINCINNATI LIFE INSURANCE COMPANY**

Proposed Insured _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>First Name</span> <span>Middle Initial</span> <span>Last Name</span> </div>	Date of Birth _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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1. a. Name and address of your personal physician? \_\_\_\_\_  
 (If none, so state.)  
 b. Date and reason last consulted? \_\_\_\_\_  
 c. What treatment was given or medication prescribed? \_\_\_\_\_

	Yes	No
2. To the best of your knowledge and belief, have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver, or gallbladder? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, or reproductive organs? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes; thyroid, or other endocrine disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints? .....	<input type="checkbox"/>	<input type="checkbox"/>
i. Deformity, lameness, or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of skin, lymph glands, cyst, tumor, or cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>
k. Allergies; anemia, or other disorder of the blood? .....	<input type="checkbox"/>	<input type="checkbox"/>
l. Excessive use of alcohol, tobacco, or any habit-forming drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>
m. AIDS or ARC diagnosed by a member of the medical profession? (See Question 9.) .....	<input type="checkbox"/>	<input type="checkbox"/>
n. Testing positive for antibodies to the HIV virus? (See Question 9.) .....	<input type="checkbox"/>	<input type="checkbox"/>
o. Any mental or physical disorder not listed above? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now under observation or taking treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you using any tobacco products now? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any change in weight in the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Other than above, have you within the past five years:		
a. Had a checkup, consultation, illness, injury, or surgery? ....	<input type="checkbox"/>	<input type="checkbox"/>
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Had electrocardiogram, X-ray, other diagnostic test? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? .....	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" answers. (Identify question number, circle applicable items. Include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.)

7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness, or disability? .....

Yes     No

8. Family History—To the best of your knowledge and belief:

a. Has any member of your family had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or committed suicide? .....

Yes     No

	Age if Living	Cause of Death	Age at Death
b. Father			
Mother			
Brothers and Sisters			
Number Living .....			
Number Dead .....			

9. If a "Yes" answer is indicated, do you want a blood test following the two ELISA and one WESTERN BLOT procedure at our expense? .....

Yes     No

10. Females only—To the best of your knowledge and belief:

a. Have you ever had any disorder of menstruation, of pregnancy, or of the female organs or breasts? .....

Yes     No

b. Are you now pregnant? .....

Yes     No

I, or we, declare that the above answers relate to the proposed insured and are complete and true. These answers are correctly recorded for the purpose of obtaining insurance and any supplemental benefit(s) applied for. I agree that they shall be included as part of my application and become a part of any contract of insurance issued on such application.

Dated at _____, 19 ____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(City)</span> <span>(State)</span> <span>(Mo.) (Day)</span> </div>	Signature of Proposed Insured _____ Signature of Parent or Guardian _____ If Proposed Insured Under Age 18
Witness _____ Must be Examiner	

LI-1696-WV (7/90)

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my health, to give to THE CINCINNATI LIFE INSURANCE COMPANY, or its reinsurer(s), any such information.

A photographic copy of this authorization shall be as valid as the original.

Date _____	Signature of Proposed Insured _____
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**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my health, to give to THE CINCINNATI LIFE INSURANCE COMPANY, or its reinsurer(s), any such information.

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Date _____	Signature of Proposed Insured _____
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**THE CINCINNATI LIFE INSURANCE COMPANY**

**MEDICAL EXAMINER'S REPORT**

10. a.	Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
	ft.    in.	lbs.	in.	in.	in.

b. Did you weigh?  Yes  No    Did you measure?  Yes  No  
 c. Is appearance unhealthy or older than stated age?  Yes  No

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	{ 4th phase		
	{ 5th phase		

12. Pulse: \_\_\_\_\_

Rate	At Rest	After Exercise	3 Minutes Later
Irregularities per min.			

13. Heart: Is there any:  
 Enlargement  Yes  No    Dyspnea  Yes  No  
 Murmur(s)  Yes  No    Edema  Yes  No  
 (describe below—if more than one, describe separately)

Location  Indicate:

Constant <input type="checkbox"/>	Apex by <b>X</b>
Inconstant <input type="checkbox"/>	Murmur area by
Transmitted <input type="checkbox"/>	Point of greatest intensity by
Localized <input type="checkbox"/>	Transmission by
Systolic <input type="checkbox"/>	
Presystolic <input type="checkbox"/>	
Diastolic <input type="checkbox"/>	
Soft (Gr. 1-2) <input type="checkbox"/>	
Mod. (Gr. 3-4) <input type="checkbox"/>	
Loud (Gr. 5-6) <input type="checkbox"/>	

After exercise: \_\_\_\_\_

Increased <input type="checkbox"/>	For comments and your impression
Absent <input type="checkbox"/>	
Unchanged <input type="checkbox"/>	
Decreased <input type="checkbox"/>	

14. Is there, on examination, any abnormality of the following:  
 (Circle applicable items and give details.)

a. Eyes, ears, nose, mouth, pharynx? .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system (include prostate)? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)? .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)? .....	<input type="checkbox"/>	<input type="checkbox"/>

15. a. Are there any hernias? .....

      b. any hemorrhoids? .....

16. Are you aware of additional medical history? .....

(A confidential report may be sent to the Medical Director)

17. a. Are you related to Applicant? .....  Yes  No

      b. Are you associated with the Applicant in any business or financial venture? .....  Yes  No

18. Have you any reason to believe that he uses or has used alcoholic beverages or drugs to excess? .....  Yes  No

Details of "Yes" answers (identify item).

19. A specimen is to be forwarded to the Home Office:

Are you forwarding a specimen of proposed Insured's urine? \_\_\_\_\_

Specific Gravity	Albumin	Sugar

To the Examining Physician:  
 The Company's normal examination fee is \$30.00. If you feel that a reasonably higher charge is warranted, please indicate amount as follows:  
 Amount of Fee \$ \_\_\_\_\_

Your overall estimate of this applicant:  First Class  Good  Fair  Poor

Examined at applicant's residence [ ] on \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.  
 applicant's business [ ]  
 examiner's office [ ]

Signature of Examiner \_\_\_\_\_

Please print or type name \_\_\_\_\_

Examiner's Social Security Number \_\_\_\_\_ Examiner's address \_\_\_\_\_  
 or Taxpayer Identifying Number \_\_\_\_\_ (Please Print)

At request of \_\_\_\_\_, Agent Office address \_\_\_\_\_

Review report carefully for completeness of all sections then mail directly and without exception to the Medical Director,  
 The Cincinnati Life Insurance Company, P.O. Box 145496, Cincinnati, Ohio 45250-5496

**THE  
CINCINNATI LIFE INSURANCE COMPANY**

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

Examiner \_\_\_\_\_ Insured \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

**NOTICE AND CONSENT FOR BLOOD, URINE OR ORAL TESTING  
WHICH MAY INCLUDE AIDS VIRUS (HIV)  
ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. This series of tests is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders and certain FDA approved oral tests.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you. If you desire, you have the right to request a complete list of the parties to whom the Insurer has released test information.

You should also be aware that the health care professional who performs the blood testing is subject to West Virginia Code §§ 16-3C-3 and 16-3C-4 which authorizes that they may disclose test results to certain limited individuals under certain limited circumstances (these relate primarily to (1) persons you authorize to see the test results, (2) health care providers who may come into contact with you or specimens obtained from you, (3) the United States centers for disease control, (4) a court order to release the results, and (5) identified sex partners and persons sharing needles). These persons are required by West Virginia Code §§ 16-3C-4 to keep test information confidential.

You may direct that test results be disclosed directly to you or if you prefer to your personal physician or other health care professional. It is strongly suggested that you designate a physician or health care professional to receive your test results so that they may properly explain the results to you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which in the Insurer's opinion, are significant. If you have not already indicated one, the Insurer may ask you at that time for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

I wish my test results to be released to:

(Check Please)

\_\_\_\_\_ Myself only.

\_\_\_\_\_ My physician, health care provider or other person indicated below.

\_\_\_\_\_ Both myself and my physician, health care provider or other person indicated below.

Physician, Health Care Provider or other person.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I have read and I understand this Notice and Consent For Blood, Urine or Oral Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to give a urine specimen and/or to the withdrawal of blood from me, the testing of that urine and/or blood, and the disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____		_____
Proposed Insured		Date of Birth
_____		_____
Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

THIS AUTHORIZATION EXPIRES AFTER 60 DAYS