

Grange Life Insurance Company

650 South Front Street, PO Box 1218, Columbus, Ohio 43216-1218

**Part 2 of Application for Insurance
MEDICAL EXAMINATION**

Policy No. _____

1. Name of Proposed Insured		2. Occupation			3. Date of Birth	
4. Family Record	If Living			If Deceased		
	Age	State of Health		Age	Year of Death	Cause of Death
Father						
Mother						
Brothers / No. Living ____ No. Dead ____						
Sisters / No. Living ____ No. Dead ____						

For Wisconsin Applicants Only: Test results of AIDS/HIV received at anonymous counseling and testing sites or results received from a home test kit need not be disclosed.

5. In the past 10 years, have you ever been treated for, or to the best of your knowledge and belief ever had any disease of: (Answer each separately)
- | | Yes | No | |
|---|--------------------------|--------------------------|---|
| A. The Brain or Nerves, Anxiety, Depression, or any Mental or Nervous Disorder? | <input type="checkbox"/> | <input type="checkbox"/> | If "Yes", give name of disorder, dates, results, name and address of attending physician. |
| B. The Nose, Tonsils, Throat or Lungs? | <input type="checkbox"/> | <input type="checkbox"/> | |
| C. Chest Pain or elevated Blood Pressure? | <input type="checkbox"/> | <input type="checkbox"/> | |
| D. The Heart or Blood Vessels? | <input type="checkbox"/> | <input type="checkbox"/> | |
| E. The Stomach, Liver, Intestines, Kidney or Bladder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| F. The Genito-Urinary System? | <input type="checkbox"/> | <input type="checkbox"/> | |
| G. The Skin, Bones, Glands, Thyroid, Eyes or Ears? | <input type="checkbox"/> | <input type="checkbox"/> | |
| H. The Rectum? (Hemorrhoids, Fistula) | <input type="checkbox"/> | <input type="checkbox"/> | |
| I. The Breast or Pelvic Organs? | <input type="checkbox"/> | <input type="checkbox"/> | |
| J. Gout, Arthritis or Rheumatic Fever? | <input type="checkbox"/> | <input type="checkbox"/> | |
| K. Diabetes, Epilepsy, Tuberculosis, Syphilis or Asthma? | <input type="checkbox"/> | <input type="checkbox"/> | |
| L. Ulcer, Colitis or Dysentery? | <input type="checkbox"/> | <input type="checkbox"/> | |
| M. Vertigo or Dizzy Spells? | <input type="checkbox"/> | <input type="checkbox"/> | |
| N. Cancer, Leukemia, or Tumor of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | |
| O. Sugar, protein or blood in urine? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Have you ever been medically diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome ("AIDS") or AIDS Related Complex ("ARC")? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Have you ever tested positive for HIV? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. A. Have you ever been under treatment or observation in any hospital? | <input type="checkbox"/> | <input type="checkbox"/> | |
| B. Have you ever had a surgical operation scheduled or completed? | <input type="checkbox"/> | <input type="checkbox"/> | |
| C. Are you maimed or deformed in any way? | <input type="checkbox"/> | <input type="checkbox"/> | |
| D. Have you in the past 10 years had any other illness, or injury not mentioned elsewhere? | <input type="checkbox"/> | <input type="checkbox"/> | |
| E. Is there a family history of diabetes, heart disease or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Do you now use or have you ever used any habit-forming drug or narcotic? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. How many alcoholic beverages do you consume daily ____ weekly ____? | | | |
| 11. Have you ever been treated for drug addiction, alcoholism or been a member of AA? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. A. Do you use tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> | |
| B. If "Yes" what? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing <input type="checkbox"/> Snuff Daily usage _____ | | | |
| C. Have you used tobacco in any form in the past and quit? <input type="checkbox"/> Yes <input type="checkbox"/> No Last date used _____
What? _____ | | | |
| 13. Are you to the best of your knowledge and belief now in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

14. State every physician or practitioner whom you have consulted, or who has treated you, during the past five years. If none, so state.

Name and Address of Each	Dates and Details	Result
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15. Give name and address of your personal physician.

16. I hereby represent to the best of my knowledge that all statements and answers as written or printed herein and in Part 1 of this application are full, complete and true, whether written by my own hand or not. I agree that they are to be considered the basis of any insurance issued hereon.

I hereby authorize any physician, surgeon, hospital or clinic to give the MEDICAL DIRECTOR of the GRANGE LIFE INSURANCE COMPANY, all information concerning my condition including history, physical and laboratory findings, diagnosis, treatment, and prognosis at any time prior to and including the date of this authorization. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date shown below.

17. Signed at _____ this _____ day of _____, 20 _____
City State

WITNESS _____
Examiner's Signature Signature of Proposed Insured

Part 3. MEDICAL EXAMINER'S REPORT

<p>1. A. How long have you known Proposed Insured? B. Are you related in any way to Proposed Insured or Agent? Which one and how related?</p>	<p>5. A. Exact height? (in shoes) _____ B. Scale weight? (in ordinary clothing) _____ C. Weight one year ago? _____ D. Girth of Chest? Forced insp. _____ Forced exp. _____ E. Girth of abdomen at greatest circumference _____</p>
<p>2. A. Does Proposed Insured impress you as being healthy? _____ B. What is the apparent age? _____</p>	<p>6. Blood pressure? Systolic _____ Diastolic _____ <small>Disappearance of sound</small></p>
<p>3. A. Pulse rate. Count full minute _____ B. Is pulse intermittent or irregular? if "Yes", describe _____</p>	<p>7. URINALYSIS: Is specimen authentic? _____ Specific gravity? _____ Protein _____ Test Used? _____ Sugar? _____ Test Used? _____</p>
<p>4. Do you know of anything in connection with the moral character, drinking habits, smoking habits (or physical condition not already detailed) which would affect their insurability?</p>	<p>NOTE: A specimen must be sent to the Home Office if: A. Sugar or protein is found. B. History of GU disorder, glycosuria, albuminuria, or if B.P. exceeds 150/100. C. Amount applies for is \$100,000 or more. D. Applicant is over age 60. E. Two or more cases of diabetes in the family.</p> <p>Are you sending a specimen to the Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

I have examined _____ in private at his (or her) residence/my office this ____ day of _____, 20 _____, and witnessed his (or her) signature herein.

Time of Examination: _____ a.m. _____ p.m. Agent requesting examination _____

Examiner's Name _____ Examiner's Phone # _____

Examiner's Address _____

Examiner's Signature _____