

- Hartford Life Insurance Company
- Hartford Life and Annuity Insurance Company  
Hartford, CT 06104-2999



## MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

### INSTRUCTIONS FOR THE MEDICAL EXAMINER — DETACH AND DISCARD BEFORE MAILING THE COMPLETED EXAMINATION TO THE COMPANY

- 1.) If you are related to the proposed insured being examined or to the agent, **PLEASE DO NOT PERFORM THIS EXAMINATION.** Please immediately advise the agent and the paramedical company so other arrangements can be made.
- 2.) Please perform the examination in private.
- 3.) **PLEASE RECORD ALL INFORMATION LEGIBLY IN YOUR OWN HANDWRITING, IN BLACK INK.**
- 4.) Please complete the Senior Exam Supplement (pages 5 and 6) on all applicants age 71 or over.
- 5.) Please cut the word flashcards (page 7) and arrange them in order as noted on the form prior to doing the Senior Exam Supplement.
- 6.) If there are any alterations or changes on pages 1, 2 or 3, the proposed insured being examined must initial them. If you have any alterations on page 4, you must initial them yourself.
- 7.) If you have any other medical information which may have a bearing on the insurability of this proposed insured, please list it on this exam questionnaire, or on a separate piece of paper and mail it with the examination to our Company.
- 8.) This examination, once begun, is the property of the Company. Please do not destroy or delay sending it to the Company
- 9.) Fees will be paid by the Company.



**MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT**

PLEASE USE BLACK INK ONLY

1 ) Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Residence (City and State) \_\_\_\_\_

2 ) Primary Physician, Health Care Provider or Clinic:  
 Name \_\_\_\_\_ Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Date of Last Visit \_\_\_\_\_

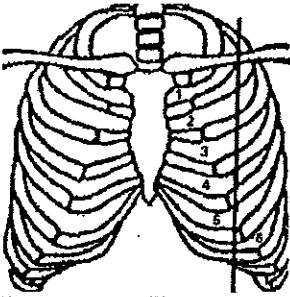
Reason for Last Visit (Please include details of evaluation, treatment and/or referrals made.)

**NOTE: GIVE DETAILS TO ALL "YES" ANSWERS ON NEXT PAGE**

	Yes	No
3. Do you take any prescription, over the counter medication or herbal remedy? (If "Yes," please provide names and doses.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had, been treated for or had treatment recommended by a member of the medical profession for:		
a. High Blood Pressure; Heart Murmur or Heart Valve Abnormality; Chest Pain; Heart Surgery; Heart Attack; Abnormal Heart Rhythm; other Heart or Vascular Disease, Condition or Disorder; Stroke or Mini-Stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Cancer, Tumor or other abnormal growth; Recurrent Infections; Lymph Gland Swelling or Enlargement; Immune System Disease, Human Immunodeficiency Virus (HIV) Infection, or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes or other Endocrine Disease; Condition or Disorder (e.g. thyroid, adrenal, pituitary, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Anemia; Blood Transfusion; Blood Vessel Disease; other Blood Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Dizziness; Fainting or Loss of Consciousness; Alzheimer's Disease or Dementia; Epilepsy or Seizure Disorder, Brain or Spinal Cord Disorder; other Nervous System Disease; Depression, Anxiety, Stress or Panic Attacks; or other Psychological Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Asthma, Chronic Bronchitis or Emphysema; other Lung Disease, Condition or Disorder; Sleep Apnea or Narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>
g. Disease of the Esophagus, Pancreas or Stomach; Ulcerative Colitis or Crohn's Disease; Chronic Indigestion, Diarrhea or Vomiting; Hepatitis or other Disease of the Liver; Hernia, other Gastrointestinal Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Bladder Disease; Kidney Disease; Prostate Disease; Sugar, Protein or Blood in the Urine; Breast Disease; other Genitourinary Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Rheumatoid Arthritis, Lupus, other Connective Tissue Disease, Condition or Disorder; Arthritis, Rheumatism or other Joint Disease, Condition or Disorder; Disease, Condition or Disorder of Bones, Back or Spine; Disease, Condition, or Disorder of Muscles, Ligaments or Tendons?	<input type="checkbox"/>	<input type="checkbox"/>
j. Ear Disease or Eye Disease, Condition or Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k. Chronic Fatigue, Fibromyalgia or Myalgia?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you engage in regular exercise? (If "Yes," provide details).	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you lost 10 or more pounds in the last 6 months (not due to change in diet)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you, in the past 5 years, used any illicit drug or prescription drug that was not prescribed by a physician? (If "Yes," provide details to include treatment recommended or given.)	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you currently consume alcoholic beverages? (If "Yes," how many per day and per week?)	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
12. Females only: Are you currently pregnant? (If "Yes," what is your due date?)	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>



### Medical Examiner's Report

<p>1) _____ Height _____ Weight _____                  Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/>                  Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>2) Blood Pressure: take 3 readings</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Systolic</td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> <tr> <td>Diastolic</td> <td></td> <td></td> </tr> </table>	Systolic			Diastolic			<p>3) Pulse:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Rate</td> <td style="width: 40%;"></td> </tr> <tr> <td>Irregularities/mn.</td> <td></td> </tr> </table>	Rate		Irregularities/mn.											
Systolic																						
Diastolic																						
Rate																						
Irregularities/mn.																						
<p>4) Please use the space provided to give details of the physical exam (→)</p> <p>Cardiovascular Exam — Is there any evidence of:</p> <p>a.) Peripheral Vascular Disease Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="margin-left: 20px;"> <input type="checkbox"/> Abnormal or diminished pulse  <input type="checkbox"/> carotid  <input type="checkbox"/> other pulse  <input type="checkbox"/> Other signs of PVD                 </p> <p>b.) Enlarged heart ----- Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c.) Heart murmur ----- Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Murmur is</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Constant</td> <td><input type="checkbox"/> Transmitted</td> <td><input type="checkbox"/> Systolic</td> <td><input type="checkbox"/> Apical</td> </tr> <tr> <td><input type="checkbox"/> Inconstant</td> <td><input type="checkbox"/> Localized</td> <td><input type="checkbox"/> Presystolic</td> <td><input type="checkbox"/> Basal</td> </tr> <tr> <td><input type="checkbox"/> Trace (0-I)</td> <td><input type="checkbox"/> Mild (II)</td> <td><input type="checkbox"/> Moderate (III)</td> <td><input type="checkbox"/> Loud (IV)</td> </tr> </table> <p>Show Location of: -- Apex by ----- X                  Area of Murmur by ----- ○                  Point of greatest intensity by ----- ○                  Transmission by ----- →</p> <p>Your impression? _____</p> <p>d.) Other CV disease (describe) _____ Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<input type="checkbox"/> Constant	<input type="checkbox"/> Transmitted	<input type="checkbox"/> Systolic	<input type="checkbox"/> Apical	<input type="checkbox"/> Inconstant	<input type="checkbox"/> Localized	<input type="checkbox"/> Presystolic	<input type="checkbox"/> Basal	<input type="checkbox"/> Trace (0-I)	<input type="checkbox"/> Mild (II)	<input type="checkbox"/> Moderate (III)	<input type="checkbox"/> Loud (IV)	<p style="text-align: center;">Details of Questions 1 - 9 USE ONLY FOR QUESTIONS ON THIS PAGE</p> 								
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<p>5) Are there any abnormalities on examination of:</p> <table style="width: 100%;"> <tr> <td>a.) Eyes</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>f.) Nervous System</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>b.) Ears</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>g.) Lungs</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>c.) Mouth, Pharynx</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>h.) Abdomen, Liver, Spleen, Kidney</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>d.) Skin, Lymph Nodes</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>i.) Musculoskeletal System</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>e.) Blood Vessels</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> </tr> </table>		a.) Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	f.) Nervous System	Yes <input type="checkbox"/> No <input type="checkbox"/>	b.) Ears	Yes <input type="checkbox"/> No <input type="checkbox"/>	g.) Lungs	Yes <input type="checkbox"/> No <input type="checkbox"/>	c.) Mouth, Pharynx	Yes <input type="checkbox"/> No <input type="checkbox"/>	h.) Abdomen, Liver, Spleen, Kidney	Yes <input type="checkbox"/> No <input type="checkbox"/>	d.) Skin, Lymph Nodes	Yes <input type="checkbox"/> No <input type="checkbox"/>	i.) Musculoskeletal System	Yes <input type="checkbox"/> No <input type="checkbox"/>	e.) Blood Vessels	Yes <input type="checkbox"/> No <input type="checkbox"/>			
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e.) Blood Vessels	Yes <input type="checkbox"/> No <input type="checkbox"/>																					
<p>6) Is the person's appearance unhealthy or older than stated age? Yes <input type="checkbox"/> No <input type="checkbox"/></p>																						
<p>7) Do you have any information or observations relating to this person's physical or mental health that are not already recorded? (If "yes," please give details.) Yes <input type="checkbox"/> No <input type="checkbox"/></p>																						
<p>8) If female, is this person menstruating today? Yes <input type="checkbox"/> No <input type="checkbox"/></p>																						
<p>9) Urinalysis</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">SPECIFIC GRAVITY</td> <td style="width: 33%;">ALBUMIN</td> <td style="width: 33%;">SUGAR</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	SPECIFIC GRAVITY	ALBUMIN	SUGAR																			
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\*\*\*\*SEND SPECIMEN TO LAB IN ALL CASES\*\*\*\*

I certify that I have carefully examined \_\_\_\_\_ whose statements and signature appearing on the reverse side hereof, were made and signed in my presence and that the examination was made in private at  My office,  Applicant's residence,  Applicant's place of business, this \_\_\_\_\_ day of \_\_\_\_\_, Examined at \_\_\_\_\_ M. D. or D. O.

City \_\_\_\_\_ State \_\_\_\_\_ (Medical Examiner's Signature)

This examination must bear the actual date that the exam was completed and no other.

Examiner Name (Print) \_\_\_\_\_ Paramedical Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_

Phone Number \_\_\_\_\_  
 Name of Agent \_\_\_\_\_ Agent's Phone Number \_\_\_\_\_



**SENIOR EXAM SUPPLEMENT**

**Instructions for the examiner:**

**PLEASE COMPLETE FOR ALL PROPOSED INSUREDS AGE 71 AND OVER**

- |     |  |
|-----|--|
| 1a. | <p>Read aloud the instructions below to the Proposed Insured. Then read aloud each of the words on the list, one at a time, while showing the corresponding flashcard, and ask the proposed insured to make up a sentence using each word. The proposed insured may not record anything on paper. It is not necessary to record the proposed insured's response; draw a line through any word that the proposed insured cannot use in a sentence.</p> <p><i>In this part of the survey, I will read a word while showing the word to you. Please use each word in a sentence. The sentence may be as long or as short as you like. Later I am going to ask you to recall the words. Do you have any questions?</i></p> |
| 1b. | <p>Follow the same instructions as for Part a. Read aloud the instructions below. When done, place the flashcard out of sight. Note the time and allow at least 5 but not more than 15 minutes before proceeding to #6.</p> <p><i>Now I am going to repeat the same words as before, show you the words and again ask you to use each in a sentence. You may make up a new sentence or use the same sentence that you used before. Do you have any questions?</i></p>  |
| 2.  | <p>Read instructions to the proposed insured and record number of seconds/minutes it takes to complete the task. The proposed insured must stand up from a seated position without using the arms of the chair for help, walk 10 feet, turn around and sit down.</p> <p><i>Please complete this exercise: Stand up without using the arms of the chair, walk to (insert place in the room that is 10 feet away), turn around, walk back, and sit down.</i></p>   |
| 3.  | <p>Ask the proposed insured about the activities listed. Record details of answers, giving specifics of activities they do perform and reasons for ones they are unable to perform or able to perform only with assistance.</p>  |
| 4.  | <p>Ask the proposed insured if they perform any regular exercise. Record details, including duration and frequency.</p>  |
| 5.  | <p>Record details of any falls, including circumstances, injuries, and treatment.</p>  |
| 6.  | <p>Read instructions to the proposed insured. <u>Record all words, including words not on the list that the applicant recalls.</u> DO NOT read the words to the proposed insured; this must be done from memory. AT LEAST 5 MINUTES BUT NO MORE THAN 15 MINUTES MUST HAVE ELAPSED FROM PARTS 1a AND 1b BEFORE DOING THIS ACTIVITY.</p> <p><i>A few minutes ago I read some words to you and you used them in sentences. Please repeat to me as many words as you can recall.</i></p>   |
| 7.  | <p>Read the instructions to the proposed insured. Allow 60 seconds for the task. Straight edge or ruler is not allowed.</p> <p><i>Please duplicate the following drawing.</i></p>  |

Upon completion of the examination, provide any additional information or observations within the details section of the answer page. Verify that the client name and date of birth, and your signature are on the Senior Supplement. Return the answer page with the other examination paperwork. Discard this instruction page and the flashcards prior to mailing any and all examination paperwork or specimens.



**Book**

**Salt**

**Flower**

**Finger**

**Train**

**Park**

**Rug**

**Chimney**

**Meadow**

**Button**

HARTFORD LIFE INSURANCE COMPANIES  
Individual Life Operations  
P.O. Box 59179  
Minneapolis, MN 55459-0179  
Telephone Number: (800) 541-6757



## HIV TEST INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

### Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

**HIV TEST  
INFORMED CONSENT FORM (Cont'd)**

**TEST RESULTS:**

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

**OTHER SOURCES OF INFORMATION:**

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

**CONSENT FOR HIV TESTING:**

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

**NOTIFICATION OF POSITIVE TEST RESULT**

In the event of a positive test result:

\_\_\_\_\_ Send the result to me at:

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize The Hartford Life Insurance Companies to send the result to another person:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize The Hartford Life Insurance Companies to send the result to the following physician or health care provider:

\_\_\_\_\_  
(Physician's Name)

\_\_\_\_\_  
(Address)

**AUTHORIZATION**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person obtaining consent

\_\_\_\_\_  
Date

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER