

PART 2

CONTINUATION OF APPLICATION to LIBERTY LIFE ASSURANCE COMPANY OF BOSTON (Complete for Medical) BOSTON, MASSACHUSETTS

PROPOSED INSURED'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH (MONTH, DAY, YEAR)
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1a. 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?

2. Have you ever been treated for or ever had any known indications of:

	YES	NO
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 (with effusion), asthma, emphysema, tuberculosis or other chronic respiratory disorder? ...	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, palpitation, high blood pressure, abnormal EKG, elevated cholesterol, 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, 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"/>

3. Have you been rejected, deferred, or discharged by the armed forces because of physical or mental conditions?

YES NO

4. Have you had any change in weight in the past year?

YES NO

5. Other than the above, have you within the past 5 years:

a. Had any x-rays, electrocardiograms, blood tests, or diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>
b. Consulted or been attended or examined by any doctor or any other practitioner or been a patient in any hospital, clinic or similar institution?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>

6. a. Except as prescribed by a licensed physician, have you ever used narcotics, barbiturates, marijuana or hallucinogenic drugs?

YES NO

b. Have you ever received treatment or joined an organization for alcoholism or drug addiction?

YES NO

7. Family History: diabetes, high blood pressure, heart disease, mental illness, or suicide?

YES NO

DETAILS of "YES" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, treatment, dates, duration and names and addresses of all attending physicians, medical facilities and patient's or clinic numbers.)

Family Record	Age, if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

8a. Have you smoked cigarettes within the past 12 months?

Yes No

8b. If yes, now many packages per day?

I hereby declare that all of the statements and answers to the above questions are complete and true, to the best of my knowledge and belief, and I agree that the foregoing together with this declaration shall form a part, designated as Part 2, of the application for insurance.

Date _____, 20____ Witness _____ M.D. Signature of Person Examined X _____

(examiner)

MEDICAL EXAMINER'S REPORT

9a. Height (in Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Full Expiration)	Abdomen, at Umbilicus	Details of Yes Answers. (Identify them)
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- b. Did you weigh? Yes No Did you measure? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

10. BLOOD PRESSURE: Make two observations at 5 min. intervals. Record all readings.

Systolic			
Diastolic 5th phase			

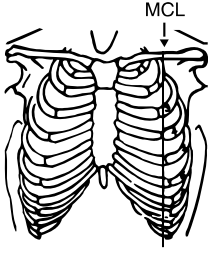
11. Pulse:

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

12. Heart: Is there any:

Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No	Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema <input type="checkbox"/> Yes <input type="checkbox"/> No
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(describe below – if more than one, describe separately)

Location	<input type="text"/>	<input type="text"/>	Indicate:	
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	X
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	O
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	O
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	➔
Systolic	<input type="checkbox"/>	<input type="checkbox"/>		
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>		
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>		
Soft (Gr 1-2)	<input type="checkbox"/>	<input type="checkbox"/>		
Mod. (Gr 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	Comments and your diagnosis <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>	
Loud (Gr 5-6)	<input type="checkbox"/>	<input type="checkbox"/>		
After Exercise				
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Absent	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		

13. LUNGS: Are the lungs and thoracic cage normal? Yes If No, Give Details

14. Is there on examination any abnormality of the following: Yes No
 (Circle applicable areas and give details)

(a) Eyes, ears, nose, mouth, pharynx?
 (If vision or hearing markedly impaired, indicate degree and correction)

(b) Skin (incl. scars): Lymph nodes; varicose veins or peripheral arteries?

(c) Nervous system (include reflexes, gait, paralysis)?

(d) Abdomen (include scars)?

(e) Genitourinary system?

(f) Endocrine system (include thyroid and breasts)?

(g) Musculoskeletal system (include spine, joints, amputations, deformities)?

15. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.)

Urinalysis: Specific Gravity	Albumin	Sugar	A specimen must be sent to Home Office if: a. Amount applied for is \$150,001 or over. b. Subject is 51 years of age or over. c. History of G-U, cardiovascular disease or if current blood pressure is above 140/90. d. History or findings of albumin or sugar. e. Family history of diabetes.
Is specimen being sent to Home Office? <input type="checkbox"/> Yes <input type="checkbox"/> No			

I certify that I made this examination at _____ A.M. _____ P.M. on _____
 My office Individual's office Individual's home Other _____

Examiner's Signature: _____ Examiner's Address _____
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