

Medical Questionnaire



(to be completed by the Medical Examiner in his own handwriting, signed in his presence and witnessed by him.)

Policy Number _____

Print first, middle and last names of Proposed Insured.

Sex	Birthdate		
M <input type="checkbox"/>	Month	Day	Year
F <input type="checkbox"/>			

1. a. Name and address of your personal physician (if none, so state) _____
- b. Date and reason last consulted? _____
- c. What treatment was given of medication prescribed? _____

2. Has the Proposed Insured ever had or been treated for any of the following conditions:

	Yes	No
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 - (a) High blood pressure, chest pain, heart attack, stroke or any heart or circulatory disorder?
 - (b) Asthma, emphysema, or other respiratory disorder?
 - (c) Ulcer, colitis, or other digestive tract disorder?
 - (d) Cirrhosis, hepatitis, or other liver disorder or any blood disorder?
 - (e) Diabetes or other endocrine disorder?
 - (f) Kidney, prostate, urinary, bladder or other genitourinary disorder?
 - (g) Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder?
 - (h) Cancer, tumor, or unexplained masses?
 - (i) Disease of the breasts, uterus, or ovaries?
 - (j) Rheumatoid arthritis or any musculoskeletal disorder?

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

11. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?

	Age if Living	Cause of Death	Age at Death
Father			
Mother			

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.

3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?
4. Has the Proposed Insured in the last five years:
 - (a) Had a physical examination?
 - (b) Had any medical treatment? (includes prescription medications)
 - (c) Been hospitalized?
5. Has the Proposed Insured ever been treated or been advised to be treated for alcoholism or alcohol abuse including membership in A.A., or been advised by a physician to reduce alcohol consumption?
6. Has the Proposed Insured ever used alcohol to excess or used narcotics, sedatives, or hallucinogens?
7. Has the Proposed Insured used marijuana in the past year?
8. Does the Proposed Insured smoke cigarettes or use tobacco in any other form?

9. If a former user of tobacco, when did Proposed Insured quit?
Date _____

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce Liberty National Life Insurance Company to issue this policy or contract applied for.

Dated at _____ City _____ State _____ Date _____

Witness _____

Signature of Medical Examiner

Signature of Proposed Insured

