



NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
 NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
 NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Application Part II

First Name _____ Middle Name _____ Last Name _____ Male Female Date of Birth (mm/dd/yyyy) _____

Social Security No. or Tax ID No. Exempt Applied for _____ Policy No./Tracking No. _____

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (_____) _____ - _____
 Date of last visit: _____ / _____ / _____ Reason for visit: _____
 Treatment or medication provided: (Provide details, name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? Yes No
 - b. Elevated blood sugar or diabetes? Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? Yes No
 - k. Any psychiatric or mental health condition (include counseling or hospitalization)? Yes No
 - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? Yes No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
5. In the last two (2) years, has the Proposed Insured had any of the following for which advice of a medical professional was not sought: chest pain or pressure, blood in urine, rectal bleeding, blood in stool, loss of consciousness, recurrent shortness of breath, persistent cough, or persistent fever? (If "Yes", circle all conditions that apply) Yes No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
- a. Had any surgery or been recommended to have surgery? Yes No
 - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more? Yes No
7. Among Proposed Insured's natural parents, brothers or sisters, is there any history of angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide relationship, age of onset and subsequent history in details on Page 2; provide type or location if cancer history.) Yes No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details on Page 2.) Yes No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home?... Yes No
 - b. Does the Proposed Insured live in a facility that provides him or her with personal care? Yes No
 - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? Yes No
 - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) Yes No

Give full details on Page 2 for all questions answered "Yes" above.



Examiner's Report – Not Part of the Application

Agent Name _____
G.O. Code _____ Agent Code _____

First Name _____ Middle Name _____ Last Name _____

10. Height ____ft. ____in. Weight ____lbs.
11. Blood Pressure. Take a second reading at the end of the examination. Report all observations. (Do not complete if examinee is under age 12.)
12. Pulse. (Do not report if examinee is under age 12.) Pulse rate at rest _____ Per/Min. Any pulse irregularity? [] Yes [] No (If "Yes", obtain EKG and provide details below)

13. Did you measure the height of the examinee? [] Yes [] No If "No", provide details below.
14. Did you weigh the examinee? [] Yes [] No If "No", provide details below.

15. Did you observe any indication of physical or mental impairment not indicated on the medical form? (If "Yes", provide details below) [] Yes [] No
16. Are you related to the person examined or has the person ever consulted you for any reason other than an insurance examination? (If "Yes", provide details below) [] Yes [] No
17. Did the person examined communicate in English well enough to understand and answer the questions on the medical form? [] Yes [] No If "No", who acted as interpreter? [] Examiner [] Agent [] Other (Name and relationship to insured. The owner or beneficiary of this insurance may not act as interpreter. A disinterested party must be used.) _____

Urinalysis is required except if examinee is under Age 12. All urine specimens are to be sent to lab for analysis.

COMPLETE THIS SECTION ONLY FOR A FULL MEDICAL EXAM.

18. Cardiovascular Examination.
a. Is there any evidence of cardiovascular disease excluding murmur? (If "Yes", provide details below) [] Yes [] No
b. Is a murmur present? (If "Yes", complete this section.) [] Yes [] No
Timing: [] Systolic [] Presystolic [] Diastolic
Location: [] Apex [] Aortic [] Pulmonic [] Other _____
Transmission: [] Axilla [] Neck [] Precordium [] None [] Other _____
Intensity: [] Soft (Gr. 1-2) [] Moderate (Gr. 3-4) [] Loud (Gr. 5-6)
Impression: _____

Table with 2 columns: Ques. No., Comments or Details. Contains 10 rows for recording answers.

I CERTIFY that I have carefully examined the person named above and not in the presence of any other person except as stated in the comments section, that I have asked each question exactly as set forth on Page 1 and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this page and Page 1 and 2, and believe them to be correctly recorded, complete and true.

Please print your name _____ Signature _____

Name of examining company _____ Date ____/____/____

Please stamp / provide Social Security No. or Tax ID No. and address. SS # or TIN # _____

Address: Street _____ City _____
State _____ Zip _____ Country _____

TO THE EXAMINER: Any erasures or alterations in this report should be initialed by you. A copy of "answers to the Examiner" (Page 1 and 2) is included in any policy issued; the "examiner's report" (this page) is not included in the policy. If you have any information included above or not shown on this form which you believe should be seen only by Underwriting personnel, please send this report and any confidential information directly to Life Medical Underwriting, New York Life, 51 Madison Avenue, New York, NY 10010.