

In continuance of application to  
**POLISH NATIONAL ALLIANCE**  
Chicago, Illinois

**Declarations to  
Medical Examiner**

**Part II  
MEDICAL**

Proposed Insured \_\_\_\_\_ Birth Date: \_\_\_\_\_  
First Name Middle Initial Last Name Month Day Year

- 1. a. 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 indication of:
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Disorder of eyes, ears, nose, or throat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, headaches; 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, asthma, emphysema, tuberculosis or chronic respiratory disorder? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, palpitation, high blood pressure, 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, appendicitis, 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 kidneys, 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"/> |
| k. Allergies; anemia or other disorder of the blood? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Excessive use of alcohol, tobacco, or any habit-forming drug? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
3. Are you now under observation or taking treatment? .....
4. Have you had any change in weight in the past year? .....
5. Other than above, have you within the past 5 years:
- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Had any mental or physical disorder not listed above? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had a checkup, consultation, illness, injury, surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had electrocardiogram, X-ray, other diagnostic test? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

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.)

6. Have you ever had military service deferment, rejection or discharge of a physical or mental condition? .....

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living .....			
No. Dead .....			

7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? .....
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? .....
9. Females only:
- a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? .....
  - b. To the best of your knowledge and belief are you now pregnant? .....

I HEREBY DECLARE that, to the best of my knowledge and belief, the statements and answers in Part II of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

Signed at \_\_\_\_\_ on \_\_\_\_\_ (Date)  
(City and State)

Witness \_\_\_\_\_ (Signature of Medical Examiner) \_\_\_\_\_ (Signature of Proposed Insured)

