

STATEMENTS TO THE MEDICAL EXAMINER
 In Continuation of and Forming a Part of My Application for Insurance to
American-Amicable Life Insurance Company of Texas

PART TWO Mail examination to: Underwriting Department / P.O. Box 2549 / Waco, Texas 76702-2549

1. Applicant (Please Print) _____	Birth Date: Month Day Year / /	Driver's License # ____ - ____ - ____	State _____
		SS#	- -

Information does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization below for a definition of "Emergency Medical Personnel".

2. (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? _____ (d) List all current medications including herb and vitamin supplements. _____			
3. To the best of your knowledge and belief do you have, or have you had or been treated in the past 5 years for (circle condition that applies):	Yes	No	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.)
(a) Asthma, pneumonia, bronchitis, emphysema, tuberculosis or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Dizziness, epilepsy, seizure, paralysis, head injury, or any mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Albumin, protein, sugar or blood in urine; any disease or disorder of the kidneys or genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Arthritis or any disease or disorder of the muscles, bones, joints, or back?	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Any disease or disorder of the ears, eyes, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Chest pains, heart attack, stroke, transient ischemic attack (TIA), high blood pressure, shortness of breath, heart murmur, phlebitis, blood clot; any disease or disorder of the heart or circulatory system? ..	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Cirrhosis, hepatitis, or any disease or disorder of the gastrointestinal tract?	<input type="checkbox"/>	<input type="checkbox"/>	
To the best of your knowledge and belief do you have, or have you ever had, or been treated for:			
(h) Malignancy, cancer or other tumors or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	
(i) Diabetes, thyroid, or endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	
(j) Anemia or any disease or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any disease or disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	
5. In the past 5 years, have you used: Heroin, morphine, cocaine, LSD, marijuana or abused prescription medication? (If Yes, indicate amount and how often and date last used)	<input type="checkbox"/>	<input type="checkbox"/>	
6. (a) Do you currently drink alcohol? (If Yes, circle type: beer, wine, liquor. Indicate amount and frequency) ...	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Have you ever received treatment for drug or alcohol usage? (If Yes, give date of treatment and last usage)	<input type="checkbox"/>	<input type="checkbox"/>	
7. (a) Have you been convicted in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Have you been convicted of a DWI or DUI or had your Driver's License suspended or revoked in the past 10 years? (If Yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you have a tattoo? (If Yes, date done)	<input type="checkbox"/>	<input type="checkbox"/>	
9. In the past 5 years, have you consulted, or been treated or examined by any physician, psychologist, psychiatrist or practitioner not named above for any cause not recorded above?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you used tobacco or any nicotine products in any form within the past twelve (12) months?	<input type="checkbox"/>	<input type="checkbox"/>	
(If Yes, type and amount, if No, date last used)			
11. If the applicant is a woman: Are you currently menstruating?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Has the natural parent, brother or sister of the proposed insured ever had tuberculosis, diabetes, cancer, heart disease, kidney disease or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Siblings			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief. I agree that these statements and answers are to be considered as the basis of any insurance written hereon.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has knowledge or records of me and my health to give such information to American-Amicable Life Insurance Company of Texas and its reinsurers. This authorization shall remain valid for two years from the date this authorization is signed. A copy of this authorization shall be as valid as the original.

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

Signed at _____ this _____ day of _____, _____ Year

Witness _____ X _____ Signature of Applicant

