



- Insurance company selection options: American General Life Insurance Company, Houston, TX; The United States Life Insurance Company in the City of New York, New York, NY; AIG Life Insurance Company, Wilmington, DE.

Member companies of American International Group, Inc.

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Personal Information

1. Proposed Insured (Complete separate Part B for each Proposed Insured)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

2. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). (If no personal physician, provide name, address and phone number of doctor last seen.)

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Date, reason, findings and treatment at last visit \_\_\_\_\_

3. Build

A. Admitted Height and Weight \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ lbs

(Examiners: Also record measured height and weight on Exam page 1.)

B. Has the Proposed Insured had any weight change in excess of 10 lbs. in the past year? [ ] yes [ ] no If yes, complete the following:

Loss \_\_\_\_\_ lbs. Gain \_\_\_\_\_ lbs. Reason \_\_\_\_\_

4. Family History

Table with 5 columns: Age if Living, Age at Death, Cause of Death, History of Heart Disease?, History of Cancer?. Rows include Father, Mother, Brother, Sister.

**5. Personal Health History**

**A.** Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

- 1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart?  yes  no
- 2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins?  yes  no
- 3) cancer, tumors, masses, cysts or other such abnormalities?  yes  no
- 4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system?  yes  no
- 5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine?  yes  no
- 6) a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine?  yes  no
- 7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder?  yes  no
- 8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder?  yes  no
- 9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders?  yes  no

*(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**B.** Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation?  yes  no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
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**C.** Has the Proposed Insured in the past three years had but NOT sought treatment for:

- 1) fainting spells, nervous disorder, headaches, convulsions or paralysis?  yes  no
- 2) any pain or discomfort in the chest or shortness of breath?  yes  no
- 3) disorders of the stomach, intestines or rectum, or blood in the urine?  yes  no

*(If yes, list condition such as: date of first occurrence; symptoms; and how treated.)*

**Details** \_\_\_\_\_  
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\_\_\_\_\_

**D.** Has the Proposed Insured ever:

- 1) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs?  yes  no
- 2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician?  yes  no

*(If yes answered to D1 or D2, please provide details below.)*

Type of drug(s)/alcohol product(s) \_\_\_\_\_ Date last used \_\_\_\_\_  
Name(s) of doctor/facility \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
Treatment Dates \_\_\_\_\_  
Support group(s) \_\_\_\_\_ Last date attended \_\_\_\_\_  
Details of any drug or alcohol related arrests \_\_\_\_\_

**5. Personal Health History (continued)**

E. Has the Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)?  yes  no  
*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
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F. Other than previously stated, in the past 10 years, has the Proposed Insured:  
1) been hospitalized, consulted a health care provider or had any illness, injury or surgery?  yes  no  
*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
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\_\_\_\_\_

2) been advised to have any diagnostic test, hospitalization or treatment that was NOT completed?  yes  no  
*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; recommended tests, medications or treatment.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition?  yes  no  
*(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

G. Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above?  yes  no  
*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details** \_\_\_\_\_  
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