Application No.:	
Agency Code No.:	

PART 2 OF APPLICATION FOR INSURANCE

STATEMENT BY THE APPLICANT MADE AND RECORDED BY (1) AGENT, IF NON-MEDICAL, OR (2) IF EXAMINATION REQUIRED.

Proposed Insured: _____ Date of Birth:_____
FIRST NAME MIDDLE INITIAL LAST NAME DAY MONTH YEAR

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

1. a. Name and address of your physician? (If none, so state) _____
   b. Date and a reason of your last consultation (If within the past 10 years) _____
   c. What treatment was given or medication prescribed _____

	Yes	No
2. Have you ever been treated for or ever had any known indication Of: (CIRCLE THE APPLICABLE ITEM) a. Disease or disorder of eyes, nose or throat?	☐	☐
b. Dizziness, fainting, convulsion, headache, speech defect, paralysis or stroke, mental or nervous disease or disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory or lung disease?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disease of the stomach, intestines, liver or gall bladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal diseases, stone or other disease of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes, thyroid or other endocrine disease?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disease or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Deformity, lameness or amputation	☐	☐
j. Disease of skin, lymph glands, cyst, tumor or cancer?	☐	☐
k. Allergies, anemia or other disease of the blood?	☐	☐
l. Excessive use of alcohol?	☐	☐
3. Do you now or have you within the past 12 months smoked cigarettes, cigars, pipes or used other tobacco relates products? If Yes, give details and how many per day? ……..	☐	☐
4. Have you ever used habit-forming drugs except on the advice of a physician?	☐	☐
5. Are you now under observation or taking treatment or medication for any disease or disorder? ……	☐	☐
6. Do you intend to seek medical advice, treatment or have any medical test performed? ……	☐	☐
7. Have you within the past 5 years: (a) Had any mental or physical disease or disorder not listed above? …	☐	☐
(b) Had a checkup, consultation, illness, injury, surgery? ……	☐	☐
(c) Been a patient in a hospital, clinic, sanitarium or other medical facility?	☐	☐
(d) Had electrocardiogram, X-ray, other diagnostic tests? ……	☐	☐
(e) Been advised to have any diagnostic test, hospitalization or surgery Which was not completed? …… ……...	☐	☐
8. Have you ever had military service deferment, rejection or discharge because of physical or mental condition? …….....	☐	☐
9. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability? …….....	☐	☐
10.Family history: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? …….....	☐	☐

	Age if living?	State of health / cause of death?	Age at Death?
Father			
Mother			
Brothers and Sisters No. Living _____ No. Dead _____			

11. (a) Height _____ft _____in or _____cm.
    (b) Weight _____ lbs. _____ or _____ kilos.

	Yes	No
12. Have you had any change in weight in the past year? ……	☐	☐
13. FEMALES ONLY: To the best of your knowledge an belief: (a) Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts? ……	☐	☐
(b) Are you pregnant? If yes, how many months? ……	☐	☐

If the answer to any question is " YES", identify question number and include diagnose, date, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities.

AIDS (Acquired Immune deficiency Syndrome) Describe in detail any affirmative answers.	YES	NO
14. Have you received medical advice or treatment in connection with AIDS or AN AIDS related condition or a sexually transmitted disease? ……	☐	☐
15. Have you been told you had AIDS or AIDS related complex?……	☐	☐
16. Have you had or been told you had a positive blood test for antibodies to the AIDS Virus (Human Immune Deficiency Virus)? ……	☐	☐
17. Do you have any of the following which are unexplained: Fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions? ……	☐	☐

I represent that I am the person named as the Proposed Insured and that the foregoing statements and answers which are made in Part Two of this application, each of which I have read and completed, truthfully and correctly recorded and are a continuation of and form a part of the application for insurance on my file to **NAGICO INSURANCES.** I hereby authorize any physician, clinic, insurance company or other organization, institution or person that has any records or knowledge of me or my health, to give to **NAGICO INSURANCES** or its representative any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment or ailment. A Photographic copy of this authorization shall be as valid as the original.

Signed at _____ _____
(City and Country) Signature of the proposed Insured

on this _____day of _____20 _____ _____
Signature of Agent or Medical Examiner

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. When an examination is begun the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid a declination.
2. An examiner is not permitted to examine his own patients or relatives or cases for an agent who is a relative.
3. Any erasures or alternations in the statements made by the proposed insured must be initialed by him.
4. Any erasures or alterations in your report must be initialed by you.
5. Both the statement of the proposed insured on the reverse side and the Medical Examiner's report must be recorded in your handwriting.
6. If you are more familiar with the metric system, please use it but indicate that you are doing so.

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

How long have you known the proposed Insured? Years: _____ Months: _____ Are you related? _____

18. a. Height (In shoes) ft. in. or. cm. | Weight (Clothed) lbs or. cm. | Males Only: Chest (Forced Expiration) in. or cm. | Chest (full Inspiration) in. or cm. | Abdomen at Umbilicus in. or cm.

b. Did you weigh? Yes ☐ No ☐
Did you measure? Yes ☐ No ☐
c. Is appearance unhealthy or older than stated age? Yes ☐ No ☐

19. Blood Pressure (if over 140) systolic or 90 diastolic, record 3 readings)

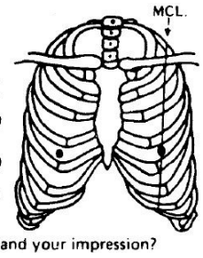
Systolic			
Diastolic (Disappearance of sound 5th phase)			

20.

Pulse	AT REST	AFTER EXERCISE	5 MINUTES LATER
Rate			
Irregularities per mm.			

21. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below- If more than one, describe separately)

Location ☐ ☐



Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐

After Exercise:

Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

22. Is there on examination any abnormality of the following: (Tick applicable items and give details.)	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? ……..……. (if vision and hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin; lymph nodes; varicose veins or peripheral arteries)?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis	☐	☐
(d) Respiratory system? ……..…….	☐	☐
(e) Abdomen (include scars)? ……..…….	☐	☐
(f) Genitourinary system (including prostate)? ……..…….	☐	☐
(g) Endocrine system (including thyroid and breast)?	☐	☐
(h) Musculoskeletal system (including spine, joints, amputations, deformities)?	☐	☐
23. Are there any hernias? ……..…….	☐	☐
24. Are you aware of any additional medical history? …… (A confidential report may be sent to the Medical Director)	☐	☐

25. Urinalysis Specific Gravity Albumin Sugar

In addition to your analysis of the urine, send a portion to a qualified Laboratory if:
A. Requested by local office
B. Applicant is over 60 years old.
C. Blood pressure is above 140 Systolic or 90 Diastolic.
D. Any urinary abnormality found or suspected.
E. There is any history of albumin or sugar, including family history of diabetes.
F. There are any findings or history of kidney, prostate, bladder or genetic urinary disease.

Examination mode:

At Applicant's place of business ☐ At _____A.M.
At Applicant's residence ☐
At Examiner's office ☐ _____P.M.
At Insurance Company office ☐

On _____ Day of _____20_____
Date Month

If the answer to any question is "Yes", identify question number and list complete details.

26. Do you know or suspect anything adverse about the proposed Insured's health, character, mentality, habits or morals not otherwise covered above?
Yes _____ No _____

_____
_____
_____
_____

Signature of Medical Examiner:

PLEASE PRINT Name of Medical Examiner:

Address of Medical Examiner:
_____
_____

City and Country:
_____