

Please print or type all information

NAME OF PROPOSED INSURED: (Please Print)	BROKER, MGA, OR LIFE SALES OFFICE: (Please Print)
BIRTH DATE: _____ SEX: <input type="checkbox"/> Male Mo. _____ Day _____ Yr. _____ <input type="checkbox"/> Female	PRODUCING BROKER: (Please Print)
PLACE OF BIRTH: _____	AMOUNT OF INSURANCE APPLIED FOR: _____
PROPOSED INSURED'S OCCUPATION: _____	PROPOSED INSURED'S RESIDENCE: _____

1. Who is your Doctor? _____ Address _____
 A. When and why did you last consult your doctor?
 B. What were you told about the findings?
 C. What treatment and drugs were prescribed?
 D. Are you still under treatment?
 E. Any prior consultations? If Yes, give details.

2. Have you been treated for or had:
 Yes No (If Yes, circle each applicable item.)
- A. Any disease or disorder of eyes, ears, nose or throat?
 - B. Dizziness, fainting, convulsions, epilepsy, head injury, headaches, speech defect, paralysis or stroke, tremor, muscle weakness, depression, other mental or nervous disorder?
 - C. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?
 - D. Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, varicose veins, phlebitis, or other heart or blood vessel disorder?
 - E. Hepatitis, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver, gall bladder, pancreas, or spleen?
 - F. Sugar, albumin, blood or pus in urine, sexually transmitted or venereal disease, stone or other kidney, bladder, prostate or reproductive organ disorder?
 - G. Allergies, anemia, bleeding tendency or other disorders of the blood?
 - H. Neuralgia, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones including the spine, back and joints?
 - I. Disorder of the skin or lymph glands, cyst, tumor or cancer?
 - J. Persistent fever, night sweats, chills, and/or diarrhea?
 - K. Diabetes, thyroid or other endocrine disorder?
 - L. Diagnosis or treatment for AIDS by a member of the medical profession?
 - M. Any mental or physical disorder not listed; had or been advised to have any checkup, consultation, illness, injury, hospitalization, treatment or surgery including an EKG, X-ray or other diagnostic test not already listed?
 - N. Are you currently receiving treatment or taking any medication?
 - O. Have you ever received or been advised to seek treatment or counseling by a member of the medical profession for alcohol or other drug use?
 - P. Have you been advised by a physician to quit using tobacco for health reasons?
 - Q. Have any of your parents, brothers, or sisters ever had diabetes?
 - R. Are you now pregnant? (If yes, give anticipated delivery date.)

Details of Yes answers (Include item #, dates, duration, medication, names and addresses of all physicians and hospitals)

3. Have you used tobacco in any form? Never Present Former *Check type:* smokeless cigar cigarette pipe
 Mo./Year quit: _____ No. of Years as a smoker: _____ No. of packs per day: _____

4. FAMILY HISTORY

	Age if living	or	At death	Cancer History?	Heart Disease or Circulatory Disorder?
Mother	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____
Father	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____
Sibling	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____
Sibling	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since Age _____

I have read the above statements and answers and agree that they are true and complete to the best of my knowledge and belief.

Dated this _____ day of _____, (month, year)

Witness _____
 Examiner

Signed _____
 Proposed Insured

*Please print or type all information***DOCTOR: Please Complete:**

1. Name of Proposed Insured _____ Birth Date: Mo. _____ Day _____ Yr. _____
2. Have you examined the Proposed Insured in the past year? _____ As a personal patient? _____ Or for insurance? _____ When _____
Any abnormal findings? _____
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3. Is the Proposed Insured your private patient? _____ If so, please give details of any history, finding, or treatment that you wish to be kept confidential.
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Date _____

Signed _____ M.D.

INSTRUCTIONS

- A. PHYSICIAN EXAMINERS: Complete both sides in full.
- B. PARA-MEDICAL EXAMINERS: Complete part II in full. If you do not have your own report form for physical measurements, you may complete page 2, omitting questions: 3, 4, 5, 6, 7, 8a, 8b, 8c, and 8f; otherwise complete your own form. If an extended examination is done, complete the blocks below, indicating the additional studies made:
 ECG CHEST X-RAY PFT BLOOD KIT OTHER _____
 (Specify)
- C. ALL EXAMINERS:
1. The completed report must be mailed to the broker, or to the Medical Director in Nashville.
 2. When the report is forwarded to the broker, detach the confidential voucher only and mail to the Medical Director, CNA International Life Company, P.O. Box 305153, Nashville TN 37230-5153.
 3. If the report is mailed to the Nashville Processing Center, leave all vouchers attached. (Paramedical facilities which bill monthly need not complete the fee voucher).
 4. The report must not be shown, given or mailed to a Broker.
 5. The broker must not be present during the examination.
 6. Fees will be paid from the Home Office. Do not accept payment from any other source.
 7. Proposed Insured should be weighed fully clothed except for coat and shoes.
 8. Report all blood pressures taken. Take a minimum of 2 readings.
If initial blood pressure is higher than 140/90, take at least two additional readings, sitting and recumbent. Question carefully for possibility of medication.
 9. When history of "Check-up" is given question carefully to determine the reason(s).