Application No. | | | |

Agent Name

PART II-FULL MEDICAL REPORT (DECLARATIONS MADE TO THE MEDICAL EXAMINER)

INSTRUCTIONS TO THE MEDICAL EXAMINER 1.This becomes Company property and must not be suppressed or destroyed. **2**. Your report of the person examined should be complete and clear and in your own handwriting. **3**. The person examined or his guardian, if applicable must initial any erasure/alteration he has made. You must initial any erasure or alteration in your report. **4**. An Examiner is not permitted to examine relatives or cases for an agent who is a relative.**5**. Please review both sides of the form before submitting, to ensure that all applicable questions have been fully and correctly accomplished. **6**. Your report is good for three (3) months. Hence, do not examine the same person more than once within the three-month period. **7**. A violation of any of the above, or any falsification made in connection with the medical examination shall result to either suspension or termination of the medical examiner's services

1. a. Full name of the Person Examined ______________________ Sex __________ Civil Status ______________

b. Date of birth ________________ Amount of insurance applied for: ________________ Valid Photo I.D. # ________________

2. Family history	Age if living	State of health	Age at death	Year	Cause of death
Father					
Mother					
Brother(s) & sister(s)					

3. a. Name and address of your personal physician
(If none, or if not consulted in the last 5 years, so state.)

b. Date of last consultation reason and result

Give the following information, so far as known, for the person being examined. If "Yes" to any question, give full details in Question 21.

	YES	NO
4. Have any of your parents, brothers or sisters had any hereditary disorders, high blood pressure or diabetes prior to age 60?	☐	☐
5. Are you under medical treatment by diet, medicine or other means?	☐	☐
6. Within the past five (5) years, have you:		
a) consulted any doctor or other health practitioner?	☐	☐
b) submitted to ECG, X-rays, blood test or other tests?	☐	☐
c) attended or been attended to in any hospital or other medical facility?	☐	☐
d) had any sexually transmitted disease?	☐	☐
7. Have you applied for or received disability benefits from any source? Why?	☐	☐
8. Have you ever had any tumor, lump, mass, cyst (cancerous or benign), or abnormal bodily growth?	☐	☐
9. Have you ever consulted or been treated by a physician for:		
a) chest pain* high blood pressure*, heart disorder or murmur?	☐	☐
b) asthma*, chronic cough*, shortness of breath or lung disorder?	☐	☐
c) diabetes* or sugar in urine?	☐	☐
d) ulcer*, colitis*, chronic diarrhea, hepatitis or other liver* or digestive disorder?	☐	☐
e) cancer, tumor, enlarged glands or enlarged lymph nodes?	☐	☐
f) anemia, bleeding or blood disorder?	☐	☐
g) fainting spells, epilepsy*, nervous or mental disorder?	☐	☐
h) urine, kidney* or bladder disorder?	☐	☐
i) arthritis?	☐	☐
j) any other illness, surgery or injury*?	☐	☐
k) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
l) A test indicating the presence of Human Immuno-deficiency Virus (HIV)?	☐	☐
10. Do you now have or have ever had any other illness, disease, injury, deformity or physical defect in any part of your body not mentioned above?	☐	☐
11. Do you smoke tobacco or any of its products? If yes, how many sticks per day, for how long have you been smoking, and the reason for stopping (if applicable)?	☐	☐
12. Except as prescribed by a physician, have you ever used cocaine, heroin or other narcotics, marijuana, LSD or amphetamines?	☐	☐
13. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received?	☐	☐
14. Have you ever used alcoholic beverages in excess, taken habit forming drugs or sought advice for alcoholism, drug abuse or other form of substance abuse thereof?	☐	☐

(* Complete supplementary questionnaire)

To be answered by women only

	YES	NO
15. Are you pregnant? If so, how many months?	☐	☐
16. Have you passed the menopausal stage?	☐	☐
17. Have you had any menstrual disorder or symptom of disease of breast, uterus or ovaries?	☐	☐
18. Have you had any abnormal pregnancies or labors? If yes, please describe.	☐	☐
19. Have you had an abortion, miscarriage or premature labor?	☐	☐
20. Date of last menstruation?	☐	☐

21. Give full details for each "Yes" answer in questions 4 – 20

a. Question No.	b. Reason-nature and severity of conditions (Include frequency, diagnosis, treatment, medication, surgery and results)	c. Onset (mm/yy)	d. Recovery (mm/yy)	e. Names and addresses of physicians, hospitals or medical facilities

I hereby consent to the application and affirm that the above particulars relating to me are true and complete and will be the basis of any contract that may arise, and all material facts which might influence the assessment of this application, have been disclosed on this application, it being understood that failure to make such disclosure renders the contract voidable. I also understand and agree that in case of future application for additional insurance, an updated medical report and other evidence of insurability shall be the basis for issuance of the additional insurance.

I hereby waive for myself and on behalf of any persons having or claiming interest in my policy issued hereunder, my legal right in connection with the disclosure of any person who may have attended or examined me in a medical capacity.

I authorize Allianz PNB Life Insurance, Inc. to process the information I have provided in accordance with the Data Privacy Act.

________________	________________	________________	________________
mm / dd / yyyy	Signature over Printed Name Medical Examiner	Signature of Person Examined (or Parent/Guardian if person examined is under 18 years old)	Signature of Payor/Policyowner

Signed at ________________

MEDICAL EXAMINATION REPORT

This examination should be made in private.

	YES	NO
22. Are you related to the Person Examined? (If "Yes", give details in Question 33.)	☐	☐
23. Has the Person Examined ever consulted you for any other reason than insurance examination (s)? (If "Yes", please give details in Question 33 for any consultation that is not described in full on the reverse side.)	☐	☐

EACH 'YES' ANSWER IN QUESTIONS 24 THROUGH 31, GIVE FULL DETAILS IN QUESTION 33.

24. Measurements (in normal heel shoes, clothed)

a. Height _________Ft. ________In. Chest (Inspiration) __________In.
b. Weight ________Lbs. Chest (Expiration) __________In.
Abdomen (Umbilicus) _______In.

25. Blood Pressure. If over 140 systolic or 90 diastolic over 5th phase, take two further readings with the interval of 5 minutes between each while the Person Examined is at rest.

	1st Reading	2nd Reading	3rd Reading
a. Systolic	_________mm	_________mm	________mm
b. Diastolic	_________mm	_________mm	________mm

26. Pulse: rate/min _________ _________ ________

	YES	NO
27. Is there, on examination, any abnormality of the ff:		
a. eyes, ears, nose, mouth, pharynx (if vision or hearing is markedly impaired, indicate degree and correction)?	☐	☐
b. skin (including scar);lymph nodes varicose veins or peripheral arteries?	☐	☐
c. nervous system (includes reflexes, gait, paralysis)?	☐	☐
d. respiratory system?	☐	☐
e. abdomen?	☐	☐
f. genitourinary system (include prostate)?	☐	☐
g. endocrine system (include thyroid and breast)?	☐	☐
h. musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
28. Are there any hernias?	☐	☐
29. Are you aware of additional medical or adverse history?	☐	☐
30. Do you recommend the acceptance of the applicant for insurance? If not give reasons.	☐	☐

31. Cardiovascular Examination. Examine heart before and exercise in the upright and recumbent positions. Do not exercise if contraindicated.

	YES	NO
a. Is there any evidence of cardiac hypertrophy, failure or other cardiovascular abnormalities excluding murmur?	☐	☐
b. Is a murmur present? (If "Yes", complete this section)	☐	☐

Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic

Location: ☐ Apex ☐ Aortic ☐ Pulmonic
☐ Other ___________________________

Transmission: ☐ Axila ☐ Neck ☐ Precordium

None ☐ Other ____________________

Intensity ☐ Soft (Gr 1-2) ☐ Mod (Gr. 3-4) ☐ Loud (Gr. 5-6)

After Exercise ☐ Increased ☐ Decreased
☐ Unchanged ☐ Absent

Impression: ____

32. Urinalysis. (Do not complete if Person Examined is less than 7 yrs. old)

a) Chemical
Albumin __________ Sugar_____________ Occult Blood _______________
Color _____________ Reaction __________ Specific Gravity ______________

b) Microscopic
RBC's _____________ Leucocytes _________ Epithelial cells _______________
Casts _____________ Crystals _____________

33. Please give question number and details to all "Yes" answers.

____

I CERTIFY that I have carefully examined the Person above (which reflects the true identity as shown in the valid I.D. presented) in private, and that I have asked each question exactly as set forth on the reverse side of this sheet and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this and on the reverse side, and believe them to be correctly recorded, complete and true.

Signed at ___________________________

_______________ at _________________
mm / dd / yyyy time(AM/PM)

____
Signature over Printed Name
Medical Examiner

PTR # & Date: _____________________________________

Please print or rubber stamp your name and address below