MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

Name	USAA #	Details of "Yes" answers. (Identify item.)
D.O.B. Mo. | Day | Yr.	Contract #	

Identification: ☐ Driver's License ☐ Other _____

1. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	ABDOMEN AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _____ lbs. ☐ Gain ☐ Loss

2. Blood Pressure (Record all readings)	INITIAL READING	FOLLOW UP READING IF NEEDED
Systolic		
Diastolic		

If initial BP Reading exceeds 129 Systolic, or 79 Diastolic. Complete 1 Additional BP Reading.

3. Resting Pulse:

Rate _____

Irregularities Per Min.

4. Heart:

a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No

b. Is murmur present? ☐ Yes ☐ No (If yes, complete 4c)

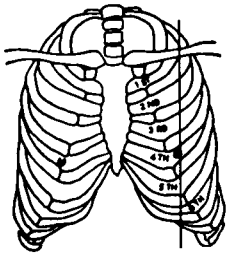
c. Murmur is:

☐ Systolic ☐ Apical ☐ Soft (Gr. 1-2)
☐ Constant ☐ Transmitted ☐ Presystolic ☐ Basal ☐ Mod. (Gr. 3-4)
☐ Inconstant ☐ Localized ☐ Diastolic ☐ Sternal ☐ Loud (Gr. 5-6)
After exercise: ☐ Unchanged ☐ Increased ☐ Other
☐ Decreased ☐ Absent

Show Location Of:

Apex by
Area of murmur by
Point of greatest intensity by
Transmission by

Your impression?



5. Is there on examination any abnormality of the following: (Check applicable items and give details.)

	YES	NO
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (incl. scars); lymph nodes; blood vessels?	☐	☐
c. Nervous system (include reflexes, gait)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6. Are there any hernias?	☐	☐
7. Have you any pertinent information not brought out above?	☐	☐

8. Urinalysis:	SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?

I certify that I made this examination on the _____ day of _____ Year _____

Examiner's signature: _____ Address _____

Examiner's name (print) _____ City _____

State _____ Zip Code _____

USAA®

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, and screening for liver or kidney disorders, diabetes, and immune disorders. By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

INFORMATION ON HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area, contact your county health department, or:

Phoenix metropolitan area: 253-2437
(Arizona AIDS Information Line)
Outside the Phoenix area: 1-800-334-1540
(Arizona Department of Health Services)

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. **Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.**

MEANING OF POSITIVE TEST RESULTS

The most commonly used tests for HIV are designed to determine the presence of antibodies or antigens to the virus. Positive HIV antibody/antigen test results do not mean that you have AIDS, but they do indicate that you have been infected with HIV, the virus that causes AIDS.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

PLEASE COMPLETE AND RETURN THIS FORM

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Road San Antonio, Texas 78288
USAA LIFE INSURANCE COMPANY of NEW YORK Service Center 9800 Fredericksburg Road San Antonio, Texas 78288

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that the disclosure or release provisions of this form will be effective up to 180 days from the date this form is signed. No HIV-related information may be disclosed to any person after that time unless the insurer obtains my written permission.

Name of Proposed Insured	Date	USAA Number

Signature of Proposed Insured or Legal Guardian

OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

Physician's Name

Address

City, State, Zip Code

Signature of Proposed Insured or Legal Guardian	Date

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to:_____
Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Facility Name: _____

Address: _____ _____

_____

To release any and all records and information regarding:

Patient's Name: _____
First Middle Last

Other Names Used: _____

Date of Birth: _____ Social Security Number: _____

Specifics to be released: _____

To be released to and exchanged between the insurance company first named above, and:

EMSI
P.O. Box 2505
Waco, Texas 76702-2505

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of EMSI in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

Signature of patient/guardian/personal representative: _____ **Date:**_____

Legal relationship to applicant:_____
(Only if signed above by guardian or personal representative)

Witness signature:_____ ☐ **Witness Required**
(Only if required) **(only if marked)**

Notary signature:_____ ☐ **Notary Required**
(Only if required) **(only of marked)**

Rev. 05/14/03