Medical Examination Report - Part 3

Jackson National Life Insurance Company®
Home Office: Lansing, Michigan
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PLEASE PRINT. USE DARK INK.

Proposed Insured's Name (first, middle initial, last name)	SSN (include dashes)	Date of Birth (mm/dd/yyyy)

1. Have you ever been treated for, or ever had any indication of:
   a. Disorder of eyes, ears, nose, mouth or throat? ☐ Yes ☐ No
   b. Recurrent dizziness, fainting, convulsions or seizures, recurrent headaches, speech defect, paralysis or stroke, mental or nervous disorder, depression or episode of attempted suicide? ☐ Yes ☐ No
   c. Persistent shortness of breath, cough, blood spitting; bronchitis, bronchiectasis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d. Chest pain, discomfort or tightness; palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e. Jaundice, intestinal bleeding; ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, recurrent diarrhea, or other disorder of the stomach, intestines, liver, gall bladder or pancreas? ☐ Yes ☐ No
   f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? ☐ Yes ☐ No
   g. Diabetes; thyroid or other glandular or endocrine disorders? ☐ Yes ☐ No
   h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, spine, back or joints? ☐ Yes ☐ No
   i. Deformity, lameness or amputation? ☐ Yes ☐ No
   j. Disorder of skin, lymph glands, cyst, tumor, or cancer? ☐ Yes ☐ No
   k. Allergies; anemia or other disorder of the blood? ☐ Yes ☐ No
   l. Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or chronic infections? ☐ Yes ☐ No
2. Have you, in the past 10 years:
   a. Consulted with or been treated by a physician or other medical/health practitioner? ☐ Yes ☐ No
   b. Had surgery of any kind? ☐ Yes ☐ No
   c. Been a patient in a hospital, clinic, or medical facility? ☐ Yes ☐ No
   d. Had an electrocardiogram, X-ray or other diagnostic test? ☐ Yes ☐ No
   e. Been advised to have an examination, consultation, or other diagnostic test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
3. Are you presently taking any prescribed medication? ☐ Yes ☐ No
4. Have you had any medication prescribed or recommended? ☐ Yes ☐ No
5. Are you presently taking any non-prescribed medication, herbal remedies, or alternative or complimentary medicine? ☐ Yes ☐ No
6. Have you ever used tobacco in any form? If "Yes," give month and year last used: _____ ☐ Yes ☐ No
7. Have you lost or gained any weight in the past year? ☐ Yes ☐ No
   If "Yes", indicate amount of gain or loss and how long current weight has been constant _____.
8. Have you, in the past five years:
   a. Used barbiturates, heroin, cocaine, marijuana or any other controlled substance except as prescribed by a physician? ☐ Yes ☐ No
   b. Been advised by a member of the medical profession to seek treatment or counseling for alcohol or controlled substance use, or to limit alcohol use? ☐ Yes ☐ No
   c. Been counseled or treated for alcohol or controlled substance use? ☐ Yes ☐ No
   d. Attended or joined any organization for alcohol or controlled substance abuse? ☐ Yes ☐ No
9. Have you ever been diagnosed or treated by a medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
10. Has any immediate family member died as a result of, or been diagnosed with, cancer, kidney or heart disease, diabetes or high blood pressure prior to age 70? ☐ Yes ☐ No
11. If Insured is under age 1, was the Insured's birth abnormal or premature? ☐ Yes ☐ No
    If "Yes," weight at birth: ____lbs. ___oz. Number of months premature: _____.
12. If Insured is female, have you had:
    a. Any disorder of breasts, uterus or ovaries? ☐ Yes ☐ No
    b. Any medical problems during pregnancy? ☐ Yes ☐ No
    c. Are you pregnant now? Anticipated date of delivery: _____ ☐ Yes ☐ No

Medical Examination Report - Part 3 (Continued)

Personal Physician's Name *If none, check here:* ☐	Phone No. (include area code)
Personal Physician's Address	Date Last Seen (mm/dd/yyyy)

Reason for last visit and results

Details of "**Yes**" answers. (If more space is needed, please attach an additional page with signature and date signed.)

No.	Dates/Duration	Diagnosis/Treatment/Result	Attending Physician's/Medical Facility's Name and Address

READ CAREFULLY BEFORE SIGNING

1) I represent to the best of my knowledge and belief that my answers and statements above are true, complete, and correctly recorded.

2) I understand that this Medical Examination Report – Part 3 (the "Report") shall be part of the Application including but not limited to examination reports, questionnaires, supplements, and amendments, and that my statements and answers on this Report (and on the Application) must continue to be true and complete as of the date coverage becomes effective. I understand that if any of my answers and/or statements on this Report or the Application change prior to coverage becoming effective, I must inform the Company in writing; and no coverage will be in effect until the Company determines whether to provide coverage, and on what terms.

Signature of Proposed Insured (or informant)	Date Signed (mm/dd/yyyy)

Measured Height (without shoes) in.	**Measured Weight** (clothed) lbs.	**Pulse** (at rest)	**Blood Pressure** At Rest _____/_____	After 10 min. _____/_____	Repeat if >138/85 _____/_____

I performed this examination at the above time and date and witnessed the proposed insured's signature. I ☐ **am** ☐ **am not** related to the applicant or producer/representative (agent).

Medical Examiner's Name	Signature
Address	