INDIVIDUAL LIFE INSURANCE APPLICATION PART II - MEDICAL EXAMINATION

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033

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1. Proposed Insured Name ____________ Birth Date ____________ SSN ____________

2. Personal Physician or Clinic Name ____________ Phone Number ____________

3. Personal Physician or Clinic Address ____________

   City ____________ State ________ ZIP ____________

4. Date last seen by Physician ____________ Reason for Consultation ____________

5. Consultation Results ____________

6. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:
   - a. Dizziness, seizures, convulsions, headaches, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression? ☐ Yes ☐ No
   - b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder? ☐ Yes ☐ No
   - c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
   - d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder? ☐ Yes ☐ No
   - e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or any other disorder of the kidney, bladder, breasts, prostate, or reproductive organs? ☐ Yes ☐ No
   - f. Diabetes, thyroid, or any other endocrine disorder? ☐ Yes ☐ No
   - g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints or bones? ☐ Yes ☐ No
   - h. Anemia or any other disorder of the blood? ☐ Yes ☐ No
   - i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? ☐ Yes ☐ No

7. Have you:
   - a. Experienced any symptom(s) for which you have not yet consulted a health care provider? ☐ Yes ☐ No
   - b. Had any operation(s) in the past 5 years? ☐ Yes ☐ No
   - c. In the past 5 years been advised to have any operation, treatment, or diagnostic tests that have not yet been performed? ☐ Yes ☐ No
   - d. Had an electrocardiogram, X-ray, or other diagnostic test in the past 5 years (excluding HIV testing)? ☐ Yes ☐ No
   - e. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? ☐ Yes ☐ No
   - f. In the past 5 years, been confined for observation, care, or treatment in a hospital or other health care facility? ☐ Yes ☐ No
   - g. In the past 5 years, consulted any health care provider(s) not already identified, for any reason including routine physical examination? ☐ Yes ☐ No
   - h. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer? ☐ Yes ☐ No

8. Are you:
   - a. Presently taking any medication(s), including non-prescription/over-the-counter medication or supplements? ☐ Yes ☐ No
   - b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbituarates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? ☐ Yes ☐ No

9. Family History

Relationship	Age if Living	Age at Death	Present Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

10. Explanations *(For any "Yes" answer to questions 6-8 on the previous page, please record information in chart below. If you need additional space, please attach a separate piece of paper to the application.)*

Question	Condition/Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

I have read the statements given in the Individual Life Insurance Application Part II - Medical Examination and affirm that they are complete and true to the best of my knowledge and belief.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Signed at (City, State) ______________________________ Date ______________

Proposed Insured Signature *(if age 15 or older)* ______________________________ Date ______________

Parent/Guardian Signature ______________________________ Date ______________
(if the Proposed Primary Insured is a minor)

Examiner Signature ______________________________ Date ______________

MEDICAL EXAMINER'S REPORT *(Provide further clarification in question 12 below.)*

1a. How long have you known the Proposed Insured? ____________

b. Are you related to him/her or to the agent? . . . . . ☐ Yes ☐ No

2a. Exact weight ____________ b. Exact height ____________

c. Weight increase/decrease in last year ____________

d. Girth (males only)

Chest at forced inspiration ____________ Abdomen ____________

3. Blood Pressure: (Use right arm while seated. Two readings are recorded, none disregarded. If systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 minutes of rest.)

	1st	2nd	3rd	4th
Systolic				
Diastolic				

4a. Rate of Pulse ____________

b. Peripheral pulses: ☐ Normal ☐ Decreased

c. Is there any irregularity or abnormality of the cardiac rhythm? ☐ Yes ☐ No

Nature of irregularity ____________

Number of irregularities per minute ____________

Number of irregularities after exercise ____________

5a. Is there any abnormality of the quality or intensity of the heart sounds? . . . . ☐ Yes ☐ No

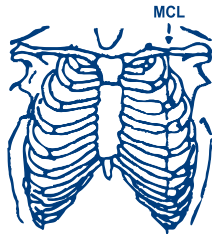
b. Are there any heart murmurs? . . . . ☐ Yes ☐ No

If "Yes", diagnosis: ☐ Functional ☐ Organic

Type ____________

Please indicate:

Timing	Intensity	Quality
☐ Systolic	☐ Faint	☐ Soft
☐ Presystolic	☐ Moderate	☐ Blowing
☐ Diastolic	☐ Loud	☐ Rough



Indicate on diagram point of maximum intensity or murmur with O and direction of transmission with ➔

6. Is the heart enlarged? . . . . ☐ Yes ☐ No

7. Does the Proposed Insured currently use or has he or she ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches?. . . ☐ Yes ☐ No

If "Yes", type and daily amount ____________

Date last used ____________

8. Have you found any evidence of past or present disease of:

a. Head or neck? . . . . ☐ Yes ☐ No

b. Eyes, ears, nose or throat? . . . . ☐ Yes ☐ No

c. Lymph nodes? . . . . ☐ Yes ☐ No

d. Brain or nervous system?. . . . . ☐ Yes ☐ No

e. Lungs or chest? . . . . ☐ Yes ☐ No

f. Abdomen?. . . . . ☐ Yes ☐ No

g. Genito-urinary system?. . . . . ☐ Yes ☐ No

h. Extremities or peripheral vessels?. . . . . ☐ Yes ☐ No

i. Skin?. . . . . ☐ Yes ☐ No

j. Any other part of the body? . . . . ☐ Yes ☐ No

9a. Is there evidence of dementia? . . . . ☐ Yes ☐ No

b. Is the Proposed Insured able to walk and to rise from a seated position without aid? . . . . ☐ Yes ☐ No

10. If your examination revealed any condition requiring further investigation or immediate treatment, have you advised the Proposed Insured? ☐ Yes ☐ No

Explain any "Yes" answers for questions 1 -10 in #12 below.

11a. Was the EKG completed? (if required). . . . . ☐ Yes ☐ No

b. Have the blood and urine specimens been sent? . . . ☐ Yes ☐ No

c. Lab ticket number ____________

d. Name of Lab ____________

For females only.

e. Was the Proposed Insured menstruating at the time the urine specimen was voided? . . . . ☐ Yes ☐ No

f. Is the Proposed Insured pregnant? . . . . ☐ Yes ☐ No

12. Remarks and Explanations

To the Medical Examiner: Any erasures or alterations in this report should be initialed by you.

Examination was made at: ☐ Proposed Insured's Residence ☐ Proposed Insured's Business ☐ Examiner's Office ☐ Other ____________

Examiner's Name *(please print)* ____________

➔ Examiner's Signature ____________ Date ____________

Examiner's Address ____________

Phone Number ____________ SSN/TIN ____________ ☐ Board Certified ☐ Board Eligible

CONSENT TO BLOOD (AND OTHER BODY FLUIDS) TESTING DISCLOSURE AUTHORIZATION

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO
ING Customer Service Center: PO Box 5075, Minot, ND 58702-5075

☐ ReliaStar Life Insurance Company, Minneapolis, MN
Employee Benefits: 100 Washington Ave., Route 7812, Minneapolis, MN 55440-9978

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PURPOSE OF THIS FORM

To evaluate your eligibility for insurance, we request that you consent to be tested to determine the presence of antibodies or antigens to the human immunodeficiency virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions will be based on these test results.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood of most people with AIDS and AIDS - related complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion) or from an infected mother to her new born infant. The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRETESTING CONSIDERATION

Many public health organizations have recommended that a person seek counseling to become informed concerning the implications of such tests before taking an AIDS-related blood test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, or that an increased premium may be charged.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who need such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

CONFIDENTIALITY OF TEST RESULTS *(Continued)*

Your test results will not be released or disclosed to any party (other than the company and related parties identified above, to whom you hereby authorize disclosure) unless:

(a) You expressly authorize their release in writing; or

(b) A public health reporting law requires disclosure; or

(c) A court order requires disclosure.

Disclosures under (b) and (c) may be made without your consent.

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results means, you are asked to list your private physician so that the Insurer can have him or her tell you the test results and explain its meaning.

Name of physician for reporting a possible test result ______________________________

Address ______________________________

City ______________________________ State __________ ZIP ______________

If you do not wish to know the results of the test, initial here: ________. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer will require you to name a physician at that time in order to receive the information. In some states positive results may only be disclosed to the physician you designate to receive the results. If you want to know the results of the test but do not at present have a private physician, initial here: ________. If state law permits, the result will be sent to you at the address provided by registered mail with delivery restricted to you only.

INFORMED CONSENT

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.

I know that I have the right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Proposed Insured Name ______________________________

Proposed Insured Signature ______________________________ Date ______________

State of Residence of Proposed Insurer ______________________________

Examiner Name ______________________________

Examiner Signature ______________________________ Date ______________