[App ID:]

AAA Life Insurance Company

Supplemental Information
Paramedical Exam

17900 N. Laurel Park Dr.
Livonia, MI 48152
(800) 624-1662

PROPOSED INSURED INFORMATION			
Full Legal Name	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth (MM/DD/YYYY) / /	Drivers License Number

The following questions must be answered by each adult Proposed Insured or by the Parent or Legal Guardian(s) for any Proposed Insured less than 18 years old.

Primary Care Physician Name	Physician Address	Physician Phone Number
Date Physician Last Consulted	Reason Physician Last Consulted	Results from Physician Visit

Have you ever been diagnosed, treated, or advised to seek treatment by a member of the medical profession for:		Fully explain all 'Yes' answers. Include diagnoses, dates, duration, and names/addresses of all attending physicians and medical facilities.
1. Heart disorder, including chest pain, circulatory disorder, high blood pressure, or elevated lipids (cholesterol or triglycerides)?	☐ Yes ☐ No	
2. Stroke, Transient Ischemic Attack (TIA or mini-stroke), or seizure?	☐ Yes ☐ No	
3. Diabetes, thyroid disorder, pancreatic disorder, liver disorder, including, but not limited to, hepatitis or kidney disorder?	☐ Yes ☐ No	
4. Lung or chronic respiratory disorder, including, but no limited to, sleep apnea or asthma?	☐ Yes ☐ No	
5. Cancer or tumor, cyst, or growth?	☐ Yes ☐ No	
6. Rheumatoid Arthritis, Lupus, Multiple Sclerosis, or other autoimmune or connective tissue disorder?	☐ Yes ☐ No	
7. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)?	☐ Yes ☐ No	
8. Any blood disorder or blood clotting disorder?	☐ Yes ☐ No	
Have you ever:		
9. Had a parent or sibling diagnosed or treated by a member of the medical profession for heart disease, cancer, or diabetes?	☐ Yes ☐ No	
10. Used any illicit drugs not prescribed by a physician, or have been advised to, or received treatment or counseling for drug or alcohol use?	☐ Yes ☐ No	
Have you in the past 10 years been diagnosed, treated, or advised to seek treatment by a member of the medical profession for:		
11. Mental or emotional disorders, including, but not limited to, anxiety, depression, bipolar, schizophrenia, dementia, eating disorders, or attempted suicide?	☐ Yes ☐ No	
12. Any central nervous system disorder including, but not limited to, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, Alzheimer's, Huntington's disease, or Cerebral Palsy?	☐ Yes ☐ No	
13. Digestive system, intestinal or stomach disorder, ulcer, or colitis?	☐ Yes ☐ No	
14. Chronic pain or fibromyalgia?	☐ Yes ☐ No	

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Have you in the past 5 years been treated by a member of the medical profession and:		Fully explain all 'Yes' answers. Include diagnoses, dates, duration, and names/addresses of all attending physicians and medical facilities.
15. Applied for or received income benefits for injury, sickness, or disability, or are you currently disabled?	☐ Yes ☐ No	
16. Been advised to have surgery, testing, or hospital care not already mentioned?	☐ Yes ☐ No	
17. Taken prescribed medications or are you currently taking any medications?	☐ Yes ☐ No	
Additional Information		
18. In the past 5 years have you used nicotine in any form?	☐ Yes ☐ No	
19. Have you lost more than 20 pounds in the past 12 months?	☐ Yes ☐ No	
20. Are you now under observation or treatment?	☐ Yes ☐ No	

I declare that all answers in this application and any attached questionnaires are, to the best of my knowledge and belief, true and complete. The answers given are the basis for any policy issued by the Company, and will be made part of the policy.

In order to determine insurability, I authorize any licensed medical practitioner, hospital, clinic, or other medical facility, insurance company, pharmacy benefit manager, MIB Inc., other organization, institution, or person having any records of the Proposed Insured's medical or prescription history, to give such information to the Company, it's reinsurers, or any agency employed by the Company to collect and transmit such information. I understand that medical records are protected by certain federal regulations. The Company will not use or disclose medical information for any purpose other than stated above, except as may be required by law. This authorization is valid for 24 months from the date signed. A copy of this authorization will be as valid as the original. I have the right to revoke this authorization in writing to the Company; however if I do, the Company may decline my application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at (City and State)	Date
Signature of Proposed Insured	Signature of Owner *(If Other Than Proposed Insured)*
Signature of Parent or Legal Guardian *(If Proposed Insured is a Minor)*	

SIGNATURE OF INTERPRETER *(if applicable)*

I, the undersigned, do hereby state that I am 18 years of age or older, and that I am not the beneficiary or owner of any AAA Life Insurance policy being applied for on the life of the above named Proposed Insured.

By signing this form as the interpreter I have met the following expectations:

- I have translated and asked all application questions of the Proposed Insured.
- I have provided all responses exactly as stated by the Proposed Insured.
- The Proposed Insured understood all questions when asked.
- The information provided is true and accurate as provided by the Proposed Insured.
- I understand that the contents of the application are confidential and that questions and answers will not be disclosed to another applicant or to any other person unless required by a court of law.

Interpreter Name (PLEASE PRINT)	Date
Signature of Interpreter	Date

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MEDICAL EXAMINER'S REPORT

AAA Life Insurance Company
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Height (in shoes) ft. in.	Weight lbs.	Weight is Scale Weight: ☐ with shoes ☐ without shoes	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

21. Exercise all applicants under age 60, unless contra-indicated. Blood Pressure (Record ALL readings)

	Initial	5 minutes later	10 minutes later	
Systolic				
Diastolic				

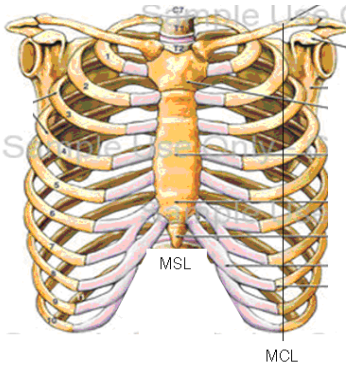
22. Pulse

	Initial	5 minutes later	10 minutes later	
Rate				
Irregularities per minute				

23. Heart - Is there any:

Displaced PMI ☐Yes ☐No Dyspnea ☐Yes ☐No
Murmur(s) ☐Yes ☐No Edema ☐Yes ☐No Bruit ☐Yes ☐No

	Murmur 1	Murmur 2
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Unchanged	☐	☐
Decreased	☐	☐
Any difference in murmur with position change	☐	☐



Indicate:
Apex by: X
Murmur area by: ◌
Point of greatest intensity by: O
Transmission by: ⇨

Details of 'Yes' answers (identify item)

24. Is there, on examination, any abnormality of the following:
(*Circle applicable items and give details*)

a. Eyes, ears, nose, mouth, or pharynx? (if vision or hearing markedly impaired, indicate degree and correction)	☐ Yes ☐ No
b. Skin (including scars), lymph nodes, veins, or peripheral pulses?	☐ Yes ☐ No
c. Nervous system (include reflexes, gait, paralysis)?	☐ Yes ☐ No
d. Respiratory system?	☐ Yes ☐ No
e. Abdomen (include scars)?	☐ Yes ☐ No
f. Genitalia (males only)?	☐ Yes ☐ No
g. Endocrine system (include thyroid and breasts)?	☐ Yes ☐ No
h. Musculoskeletal system (include spine, joints, amputation, and deformities)?	☐ Yes ☐ No

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		Details of 'Yes' answers (identify item)
25. Are you aware of additional medical history: Signs, symptoms, or laboratory findings? (A confidential report may be sent to the Medical Director)	☐ Yes ☐ No	
26. Have you any reason to believe that the Proposed Insured uses or has used alcoholic beverages or drugs to excess?	☐ Yes ☐ No	

Are you forwarding a specimen to the laboratory? (if 'No', provide reason)	☐ Yes ☐ No

Signed at (City and State)	Date	Signature of Medical Examiner

Mail this report to: AAA LIFE INSURANCE COMPANY
17900 N. Laurel Park Dr.
Livonia, Michigan 48152

DO NOT DETACH DO NOT DETACH

CHECK REQUISITION
AAA Life Insurance Company

NAME AND ADDRESS OF MEDICAL EXAMINER (PAYEE)	MEDICAL EXAMINER'S SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
	NAME OF PROPOSED INSURED
	FOR HOME OFFICE USE ONLY
	POLICY NUMBER
	APPROVED BY
	ACCOUNTING DEPARTMENT