MIDLAND NATIONAL®
Life Insurance Company

2336CCA

APPLICATION PART II

Proposed Insured (Please Print) First Name	M.I.	Last Name	Birth Date (Month, Day, Year)	Social Security Number

1. Have you ever smoked cigarettes, cigars, pipes, or used tobacco in any form, including smokeless tobacco, nicotine patch, gum or other substitutes?
☐ Yes ☐ No If 'yes', provide: Type of product(s) used _____
Amount Used: How often: Daily Weekly Monthly Date of last use mm/yy _____

2. In the past 10 years, have you ever had or been diagnosed by a licensed medical professional, treated or recommended to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) for any of the following disease(s) or disorder(s):	Yes	No
(a) Angina, chest pain, heart attack, heart failure, heart surgery, irregular heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, circulatory disorder, valvular heart disease, cardiomyopathy or heart murmur?	☐	☐
(b) High blood pressure, hypertension or cholesterol levels?	☐	☐
(c) Stroke, seizures, epilepsy, dizziness, fainting or dementia?	☐	☐
(d) Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles?	☐	☐
(e) Arthritis, chronic pain, fibromyalgia, lupus or scleroderma?	☐	☐
(f) Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia?	☐	☐
(g) Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea?	☐	☐
(h) Diabetes, Pre-diabetes or impaired glucose tolerance, sugar in the urine, disease or disorder of the adrenal, parathyroid, pituitary or thyroid glands?	☐	☐
(i) Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal PAP smear without subsequent normal PAP smear or protein or blood in the urine?	☐	☐
(j) Anemia, hemophilia or clotting disorder, excluding HIV (Human Immunodeficiency syndrome)?	☐	☐
(k) AIDS (Acquired Immune Deficiency Syndrome), any other disease or disorder of the immune system, or a positive HIV (Human Immunodeficiency syndrome) test in connection with an application for insurance?	☐	☐
(l) Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis or liver failure?	☐	☐
(m) Depression, anxiety disorder, stress disorder, eating disorder?	☐	☐
3. Other than indicated above, have you:		
(a) In the past 10 years used barbiturates, hallucinatory drugs, narcotics including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any other derivatives of these drugs not prescribed by a licensed medical practitioner?	☐	☐
(b) Been advised by a licensed medical professional to get, or undergone any treatment, counseling or hospitalization for drug abuse?	☐	☐
(c) Been advised by a licensed medical professional to get, or undergone any treatment or counseling or hospitalization for alcoholism, alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or treatment for alcohol use? Or, drink on average more than 3 alcoholic drinks per day?	☐	☐
(d) Had a parent or sibling who before age 60 was diagnosed with or died from cardiovascular disease, stroke, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis or polycystic kidney disease? If yes, provide age at onset and current age if living. If deceased, age at death.	☐	☐
(e) Had a weight gain or loss of 10 or more pounds within the past 12 months for any reason other than pregnancy?	☐	☐
(f) In the past 12 months been recommended by a licensed medical professional to have a check up, EKG, X-ray, blood or urine test or any other diagnostic test that has not been performed or are you now planning to seek medical advise or treatment for any reason (excluding HIV testing unless such test was in connection for an application for insurance)?	☐	☐
(g) In the past 12 months been recommended by a licensed medical professional to be admitted to a hospital, medical facility, nursing home or assisted living facility?	☐	☐
4. Are you currently taking any prescription medications, herbal remedies or non-prescription medications for any disease or disorder not listed above? If yes, list the medications and remedies and the reasons for which they are taken.	☐	☐
5. Are you currently receiving or have an application pending for any illness or disability benefits or compensation?	☐	☐

DETAILS TO 'YES' ANSWERS FOR QUESTION 2 THROUGH 5

Question #	Include Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician and Hospital

6. If not listed above, please provide full name, address and phone numbers of licensed medical professional(s) consulted in the past five years. Include date and findings of last visit and tests performed and treatment received.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and are made to induce the Midland National Life Insurance Company to issue the policy or certificate applied for.

PART III – MEDICAL EXAMINER'S REPORT

7a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.	b. Did you weigh? c. Did you measure? d. Is appearance unhealthy or older than stated age?	Yes	No
						☐ ☐ ☐	☐ ☐ ☐

8. Blood Pressure (Record ALL readings)	1st	2nd	3rd
Systolic			
Diastolic 5th phase			

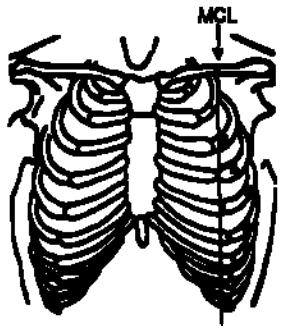
9. Pulse	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

10. Heart: Is there any: Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below – if more than one, describe separately)

	1st Murmur	2nd Murmur
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:	☐	☐
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:

Apex by X
Murmur area by O
Point of greatest intensity by O
Transmission by



Please give your diagnosis of the lesion and any other comments.

11. Is there on examination any abnormality of the following:
(Circle 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; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐

Details of "Yes" answers. (Identify item.)

To be completed by either medical or paramedical examiner.

	Yes	No
1. How long have you known Proposed Insured? _____		
2. Has the Proposed Insured ever consulted you professionally?	☐	☐
3. Are you related in any way to Proposed Insured or Agent?	☐	☐
4. Are you a business associate of either the Proposed Insured or Agent? If yes, which one and how associated?	☐	☐
5. Are you aware of any additional information which might have a bearing upon the Proposed Insured's insurability? (A confidential report may be sent to the Medical Director.)	☐	☐

Send Urine Specimen To Laboratory In Container Provided. If Blood Specimen Is Required, Send To Laboratory In Kit Provided.

Other Services Performed With This Examination:
☐ Resting EKG ☐ Chest X-ray ☐ Venipuncture
☐ Treadmill EKG ☐ DBS ☐ Other _____

Is urine specimen being sent to laboratory? ☐ Yes ☐ No
Is person examined menstruating? ☐ Yes ☐ No

I certify that I made this examination at
_____ A.M.
_____ P.M. on the _____ day of_____ , _____

Examination made at
☐ my office ☐ Individual's Place of Business
☐ Individual's Residence ☐ Other _____

Examiner's Signature	Examination Fee	Tax I.D. or S.S. No. (IMPORTANT: Payment cannot be made without number.)
Examiner's Name (Print Full Name)	Examination Authorized By (Name of Agent – Please Print)	
Examiner's Address (Street, City, State, Zip)		Examiner's Telephone Number ( )

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AUTHORIZATION: To determine eligibility for insurance, the undersigned applicant(s) (I) authorize any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or other organization, institution, or person, or employer having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and any other nonmedical information of me or my minor children to give to Midland National Life Insurance Company (the Company) or its legal representative, any and all such information. I authorize the Company or its reinsurers to make a brief report of my personal health information to Medical Information Bureau, Inc. I also authorize the Company to conduct a personal telephone interview in connection with my application; and to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. This authorization is valid for 30 months from the date signed. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

Signed At (City and State)	Date
Witness Signature	Proposed Insured Signature