THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

MEDICAL EXAMINATION INSTRUCTIONS

Please read carefully before beginning the Examination.

Instructions
Complete the Medical Questionnaire (form 90-4A) and the Medical Examination (form 90-4B) in their entirety.

Licensed MD or DO
To perform this examination you must:

- have a medical license in good standing from the state where this exam is being performed, and
- maintain malpractice/professional liability insurance in an amount no less than that required by statute and/or regulation in the state where this exam is being performed, or $1,000,000 per occurrence and $3,000,000 in the aggregate per year, whichever is greater;
- maintain general liability insurance in an amount no less than $1,000,000 per occurrence and $2,000,000 in the aggregate per year, and
- be a Doctor of Medicine or Doctor of Osteopathy and a Board candidate or Board certified in Internal Medicine, Family Practice, Emergency Medicine, Occupational Medicine, Preventive Medicine, or Pediatrics.

Personal, Business or Professional Relationships
This examination should not be performed if you:

- are related to or have a personal, professional or business relationship with the person to be examined or the Northwestern Mutual Financial Representative (Agent), or
- have any business association with a Northwestern Mutual Network Office.

Non-English Speaking Insureds
All examinations must be recorded in English and performed within U.S. borders. Financial Representatives, Associate Financial Representatives, Network Office staff, Insured's or Financial Representative's family members, business associates, or legal representatives may not be present or used to translate any part of the examination.

- If the Insured does not speak English and you are fluent in his or her spoken language, you may proceed with the examination.
- If you are **not** fluent in the Insured's spoken language, prior to initiating the exam, call the phone number the Financial Representative has provided to use a Northwestern Mutual authorized interpreter.
- If the Financial Representative has not provided the telephone number to call for a Northwestern Mutual authorized interpreter, do not perform the exam. Contact the Financial Representative.

Identification
If the Insured cannot or will not provide proper picture or other verification of his/her identity, e.g., driver's license, please do not perform the exam. Contact the Financial Representative.

Complete All Exams in Private
Examinations need to be completed in private. No one other than the Insured may be present during this exam. If the Insured requests a gender specific examiner, nurse or medical assistant, one should be provided. If the Insured is a minor (17 years old or younger), a parent/legal guardian must be present.

Complete History and Exam
Legibly record all answers in your own handwriting using a pen (blue or black ink). All questions are to be read by you to the Insured. If the Insured refuses to answer a question or refuses any part of the exam, indicate this on the examination form. Do not write "deferred" for any response. If any part of the history or examination cannot be completed adequately, the reason should be indicated on the last page of the examination form. Report any other health information obtained during the examination process even though such information may not have been specifically required. On the **Medical Questionnaire** (form 90-4A) – Please note for Question 31: If pipe, snuff and/or chewing tobacco have been used in the past 3 years, be sure to record in the "Details" section the type of each product and the annual cumulative use for each.

Sensitive Information
Any particularly sensitive confidential information which you believe should be sent directly to the home office may be included in the Medical Examiner's Additional Remarks Section on the exam. Detach and mail directly to: Medical Director, Northwestern Mutual, P.O. Box 2950, Milwaukee, WI 53201-2950.

Alterations
All alterations on the Medical Questionnaire (form 90-4A) must be initialed by the Insured for legal purposes. Your alterations on the Medical Examination (form 90-4B) should be initialed by you.

No Financial Representative Influence
The Financial Representative may not proof, edit, rewrite, influence or discuss any part of the exam or medical history with the Insured, parent/legal guardian, your technician, or you at any time. Such activity should be reported to the Manager of New Business Requirements at the Northwestern Mutual home office at (414) 271-1444.

Property of The Northwestern Mutual Home Office
This examination form, and all information collected in connection with the completion thereof, along with any diagnostic studies (i.e., EKG, Chest X-rays, etc.), are the property of the Northwestern Mutual home office and may not be (1) used by you for any purpose other than the requested review, or (2) disclosed to any third party without prior written consent from the Director – Underwriting Requirements, Northwestern Mutual, P.O. Box 2950, Milwaukee, WI 53201-2950. All completed examinations and studies must be forwarded to the Northwestern Mutual Financial Representative, Network Office or home office. If incomplete, send directly to: Director – Underwriting Requirements. Please notify Northwestern Mutual promptly in the event of any theft, loss, or misplacement of confidential information, in whatever form.

The home office address is: New Business Department, Northwestern Mutual, 720 E. Wisconsin Avenue, Milwaukee, Wisconsin 53202.

Blood/Urine Collection
Specimen collection kits will be provided by the Paramedical Corporate Office (or the Financial Representative if you are not affiliated with a Paramedical Company). Specimens must be sent to the designated Northwestern Mutual laboratory. Instructions for collection are contained within the kits. The Paramedical Company name must be clearly marked on the Laboratory Consent form. A state specific HIV consent form, if required, must be completed before the blood is drawn. Lab consent form must be signed prior to blood collection. If the Insured will not sign the lab consent form, do not collect blood. Contact the Financial Representative.

Cardiovascular Studies and Chest X-ray Studies (PA and lateral views)
Requests for cardiovascular (EKG, Treadmill) and Chest X-ray studies will be communicated by either the Financial Representative or Paramedical Company. Forward the following with the exam as directed by the Paramedical company or the Northwestern Mutual Financial Representative: EKG – tracing only; Treadmill - all original tracings and report; Chest X-rays – PA and lateral films/CD and interpretation; to the Paramedical Office, Northwestern Mutual Financial Representative, Network Office or home office. If sending Chest X-rays, use a ground carrier utilizing a tracking number (such as UPS, Airborne Express, etc.). If sent to the home office, send directly to: New Business/Medical Studies, Northwestern Mutual, 720 East Wisconsin Avenue, Milwaukee, Wisconsin 53202. If you have questions or need guidelines to complete these studies, contact your Paramedical Corporate Office, (or if you are not affiliated with a paramedical company, the Northwestern Mutual home office, Medical Studies Division, at (414) 665-7379).

CALIFORNIA
90-0079-03
0608

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

MEDICAL QUESTIONNAIRE

INSURED NAME (First, Middle Initial, Last)	POLICY NUMBER

Each question must be individually asked and answered. Give details of "Yes" answers below:

31. Have you used tobacco or nicotine in any form in the last 10 years? If "yes", indicate type and date last used: **YES** ☐ **NO** ☐

☐ Cigarette, pipe, snuff, chewing tobacco, nicotine gum, nicotine patch or other form of nicotine . . . . . Date last used ___/___/___

☐ Cigar . . . . . Date last used ___/___/___
Frequency of cigar use . . . . . No. per year _____

32. Are you taking medication or drugs (legal or illegal, prescription or nonprescription) for any reason? If yes, list and explain. **YES** ☐ **NO** ☐

33. In the last 10 years, have you had, been told you had or been treated for:

	YES	NO
a. Disorder of eyes (including double vision), ears, nose, mouth, throat or speech?	☐	☐
b. Dizziness, loss of balance, headaches, seizures or convulsions, muscle weakness, tremor, paralysis, stroke, memory loss, or any disease of the brain or nervous system?	☐	☐
c. Anxiety, depression, stress, or any psychological or emotional condition or disorder?	☐	☐
d. Persistent shortness of breath, hoarseness, cough, coughing up blood, asthma, emphysema, tuberculosis, or any lung or respiratory disorder?	☐	☐
e. Jaundice, hepatitis, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver, gall bladder or pancreas?	☐	☐
f. High blood pressure, chest pain, chest discomfort, chest tightness, irregular heart beat, heart murmur, heart attack or any disorder of the heart or blood vessels?	☐	☐
g. Sugar, albumin, blood or pus in the urine, sexually transmitted or venereal disease, or any disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
h. Diabetes, thyroid or any glandular (endocrine) disorder?	☐	☐
i. Cancer, tumor, polyp, or disorder of the lymph gland(s) or breast(s)?	☐	☐
j. Anemia, bleeding tendency, or any disorder of the blood (Excluding HIV)?	☐	☐
k. Arthritis, sciatica, gout, or any disorder of the muscles, bones, joints, spine, back or neck?	☐	☐
l. Chronic or unexplained fatigue, fever, or illness?	☐	☐
m. Any allergies?	☐	☐
n. Any disorders of the skin?	☐	☐
o. Deformity, lameness or amputation?	☐	☐

34.

	YES	NO
a. Have you sought or received counseling or treatment for the use of alcohol or drugs or missed work because of alcohol or drug abuse?	☐	☐
b. In the last 10 years, have you used marijuana, cocaine, heroin, amphetamines or hallucinogens?	☐	☐
c. In the last 10 years, have you used any tranquilizers, sedatives or narcotic drugs?	☐	☐
d. In the last 10 years, have you used legally prescribed drugs in excess of dosages prescribed by a physician or medical practitioner?	☐	☐

35. Are you pregnant? If yes, due date:_____ **YES** ☐ **NO** ☐

For all "Yes" responses:
- Identify question numbers.
- State signs, symptoms and diagnosis of each illness or injury.
- List the details and results of any treatment.
- **For each health care provider consulted,** list the name, full address, telephone number and dates.

DETAILS

INSURED NAME (First, Middle Initial, Last) PRINT NAME

Each question must be individually asked and answered. Give details of "Yes" answers below:

36. Other than as previously stated on this application, in the last five years have you:

	YES	NO
a. Consulted any other health care providers (medical doctor, psychiatrist, psychologist, chiropractor, counselor, therapist or other)?	☐	☐
b. Been a patient in a hospital, clinic or medical facility?	☐	☐
c. Had any diagnostic studies (EKG, x-ray, blood tests or any other except for an HIV test)?	☐	☐
d. Had surgery?	☐	☐
e. Been advised to have any test, consultation, hospitalization, or surgery which was not completed?	☐	☐

37.

	YES	NO
a. During the last 6 months have you worked in your regular occupation less than your usual number of hours per week because of any sickness or injury?	☐	☐
b. Have you ever requested or received payments, benefits, or a pension because of any injury, accident, sickness or disability?	☐	☐

38.

	YES	NO
a. Do you have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide, or any hereditary disease?	☐	☐

b. Family History

	Age if Living	Medical History or Cause of Death	Age at Death
Father			
Mother			
Brothers or Sisters			

39.

	YES	NO
a. Height _____ft. _____in. b. Weight _____lbs.		
c. Have you lost weight in the past 6 months? If yes, loss was _____lbs. Reason for weight loss _____	☐	☐

40. (Do not complete for Disability Insurance)
If the insured is under age 1, what was the weight at birth? _____lbs. _____ozs.

41.

	YES	NO
a. Have you been told that a test for the virus that causes AIDS, the HIV virus, that was previously taken for the purpose of obtaining insurance, was positive, reactive, abnormal or indeterminate?	☐	☐
b. Has a member of the medical profession ever diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)?	☐	☐

42. Who is your regular or personal physician, doctor or health care provider? ☐ None
Name: _____
Address: _____
City, State & Zip Code: _____
Date last seen: ___/___/___ Phone number: (_____) _____-_____
Reason: _____

For all "Yes" responses:
- Identify question numbers.
- State signs, symptoms and diagnosis of each illness or injury.
- List the details and results of any treatment.
- **For each health care provider consulted,** list the name, full address, telephone number and dates.

DETAILS

I declare that my answers and statements are correctly recorded, complete and true to the best of my knowledge and belief. Statements in this application are representations and not warranties.

Signed in my presence ➧ _____ ➧ _____

MEDICAL EXAMINER Signature of **INSURED** (or Parent/Guardian)

➧ _____

DATE (MM/DD/YYYY)

THE NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY
720 E. WISCONSIN AVENUE, MILWAUKEE, WISCONSIN 53202

MEDICAL EXAMINATION

INSURED NAME (First, Middle Initial, Last) PRINT NAME			☐ FEMALE ☐ MALE
DRIVER'S LICENSE NUMBER	DRIVER'S LICENSE STATE	WAS A PICTURE ID SHOWN FOR VERIFICATION? ☐ YES ☐ NO	SOCIAL SECURITY NUMBER
AMOUNT APPLIED FOR $	OCCUPATION		DATE OF BIRTH *(MM / DD / YYYY)*

1. A. HEIGHT *(WITHOUT SHOES) (PHYSICALLY MEASURE)*
_____ FT _____ IN

B. WEIGHT *(CLOTHED, WITHOUT SHOES) (PHYSICALLY WEIGH)*
_____ LBS.

2. BLOOD PRESSURE *(NOT REQUIRED UNDER AGE 10)*
Take three readings at rest while seated.
SYSTOLIC/DIASTOLIC ____/____ ____/____ ____/____

CUFF SIZE
☐ Regular ☐ Large
☐ Other _____

3. PULSE *(RECORD FOR 1 FULL MINUTE)*
RATE _____ / MIN

IRREGULARITIES / MIN
☐ NONE ☐ YES – IF YES, # IRREGULARITIES PER MINUTE: _____ / MIN

4. IS THE INSURED CURRENTLY MENSTRUATING? ☐ YES ☐ NO (NOTE: If ordered, please collect blood and urine even if menstruating.)

EXAMINATION
PERFORM ONLY WHAT IS REQUESTED ON THE EXAM.

GIVE DETAILS TO ALL "YES" ANSWERS.
IDENTIFY QUESTION NUMBERS.

5. On examination is there any abnormality of: *(If yes, give details at right)*

	YES	NO
a. Skin? *(includes scars, suspicious lesions, rashes, etc.)*	☐	☐
b. Eyes? *(include EOM's, pupils, or retinal abnormalities - Note any visual limitations)*	☐	☐
c. Ears/Nose? *(Note any hearing limitations)*	☐	☐
d. Mouth/pharynx?	☐	☐
e. Neck? *(include thyroid, lymph nodes, carotids)*	☐	☐
f. Chest? (*do **not** complete a breast exam - include chest contour and breath sounds)*	☐	☐
g. Heart? *(include PMI - if murmur is present, indicate whether systolic or diastolic, location and intensity)*	☐	☐
h. Nervous System? *(include gait, reflexes, motor, and sensory)*	☐	☐
i. Musculoskeletal? *(include spine, joints, amputations, deformities)*	☐	☐
j. Vascular? *(indicate carotid, radial, popliteal, and pedal pulses - Note the presence of any bruits)*	☐	☐

COMPLETE MEDICAL EXAMINER QUESTIONS ON PAGE 2

INSURED NAME (First, Middle Initial, Last) PRINT NAME

MEDICAL EXAMINER

6. ARE YOU AWARE OF ANY ADDITIONAL MEDICAL HISTORY OR OTHER FACTS CONCERNING THE INSURED'S HEALTH, HABITS, ENVIRONMENT, OR OTHER PERSONAL FACTORS WHICH NORTHWESTERN MUTUAL SHOULD HAVE IN EVALUATING THE INSURED? ☐ YES ☐ NO
IF YES, ENTER THESE BELOW. *(FOR PARTICULARLY SENSITIVE INFORMATION, COMPLETE "MEDICAL EXAMINER'S ADDITIONAL REMARKS" FORM AND MAIL AS DIRECTED ON THE FORM.)*

7. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE INSURED?
☐ YES ☐ NO IF YES, EXPLAIN: _____

8. ARE YOU RELATED TO OR DO YOU HAVE A PERSONAL, PROFESSIONAL, OR BUSINESS RELATIONSHIP WITH THE FINANCIAL REPRESENTATIVE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

9. ARE YOU CONNECTED WITH A NORTHWESTERN MUTUAL NETWORK OFFICE THROUGH EMPLOYMENT, FAMILY RELATIONSHIP OR OTHERWISE?
☐ YES ☐ NO IF YES, EXPLAIN: _____

10. WAS ANY PORTION OF THE EXAMINATION ASKED OR ANSWERED IN A LANGUAGE OTHER THAN ENGLISH? ☐ YES ☐ NO

IF YES:

WHAT PORTION OF THE EXAMINATION WAS TRANSLATED? _____

IN WHAT LANGUAGE WAS IT TRANSLATED? _____

NAME OF INTERPRETER? _____

INTERPRETER'S COMPANY? _____

RELATIONSHIP OF INTERPRETER TO INSURED? _____ ☐ NO RELATIONSHIP

RELATIONSHIP OF INTERPRETER TO FINANCIAL REPRESENTATIVE? _____ ☐ NO RELATIONSHIP

11. PLACE OF EXAMINATION
☐ MY OFFICE ☐ INSURED'S HOME ☐ INSURED'S PLACE OF BUSINESS ☐ PARAMEDICAL BRANCH OFFICE ☐ OTHER (SPECIFY LOCATION) _____

12. DATE OF EXAMINATION *(MM / DD / YYYY)* | TIME OF EXAMINATION _____ ☐ AM ☐ PM

13. PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION

14. THE FOLLOWING SPECIMENS HAVE BEEN COLLECTED AND SENT TO THE AUTHORIZED INSURANCE LAB USING KIT:
☐ BLOOD
☐ URINE

ATTACH BAR CODE HERE FROM LABORATORY CONSENT FORM

BAR CODE

THE FOLLOWING STUDIES ARE ATTACHED TO THE EXAM OR WILL BE SENT TO THE HOME OFFICE:

☐ RESTING EKG *(The Insured's name, date of birth and date of the EKG must be printed on the EKG strip. The Insured must sign and date the EKG.)*

☐ TREADMILL EKG *(All original tracings and report. Report must include Insured name, date of birth, date of study, and reason for stopping, along with description of any symptoms experienced, physician name and signature.)*

☐ PA and LATERAL CHEST X-RAYS *(Deliver as directed by the paramedical company (if applicable), or Financial Representative, or send the films/CD and interpretation via UPS, Airborne Express or Federal Express directly to the home office address on the instruction page.)*

☐ OTHER *(Specify)* _____

I certify that the above is a record of a careful examination of the Insured and that I completely and correctly recorded the answers on the Medical Questionnaire (form 90-4A) before the Insured signed it. I also certify that I have a medical license in good standing from the state where this exam was performed. I certify that I have complied with all instructions on the Medical Examination Instructions page of this exam form.

_____
MEDICAL EXAMINER NAME *(PRINT OR STAMP)*

➧ _____ MD/DO
SIGNATURE OF MEDICAL EXAMINER

NAME OF FACILITY/PARAMEDICAL COMPANY *(PRINT OR STAMP)*	PHONE NUMBER ( )
OFFICE ADDRESS	CITY/STATE/ZIP CODE

NB-500-2

MEDICAL EXAMINATION – ADDITIONAL REMARKS

Complete this statement only in situations described below:

(1) If the examination is not completed at the first interview or further observation is indicated.
(2) If further evaluation is recommended.
(3) Any particularly sensitive confidential information to be sent only to the home office (as indicated in the Medical Examination Instructions).
(4) If for any reason you did not complete or refused to perform the examination. Please include the reason why.

INSURED NAME (FIRST, MIDDLE INITIAL, LAST) PRINT NAME		
DATE OF BIRTH (MM / DD / YYYY)	SOCIAL SECURITY NUMBER	RESIDENCE (CITY / STATE)
PRINT FULL NAME OF FINANCIAL REPRESENTATIVE WHO REQUESTED EXAMINATION		

REMARKS

ADDRESS

PHONE NUMBER

MEDICAL EXAMINER NAME (PRINT)

DATE (MM/DD/YYYY)

SIGNATURE OF MEDICAL EXAMINER

MAILING INSTRUCTIONS	
IF...	**THEN...**
Additional remarks are made	• detach this entire page from exam • send to: Medical Director Northwestern Mutual P.O. Box 2950 Milwaukee, WI 53201-2950 • return exam to Financial Representative
No additional remarks are made	• return entire exam to Financial Representative

TO EXPEDITE PAYMENT:

If this service was scheduled through a paramedical company,
please submit your billing information to that paramedical company.

If this service was <u>NOT</u> scheduled through a paramedical company,
please submit an itemized invoice to the address below. Northwestern Mutual reserves the right to withhold payment if any of the following information is not included on the invoice:

- ✓ Northwestern Mutual Financial Representative's full name
- ✓ Insured's name (First, Middle Initial, Last)
- ✓ Insured's date of birth
- ✓ Insured's Social Security Number
- ✓ Date(s) of service
- ✓ Service(s) performed
- ✓ Dollar amount charged for each service
- ✓ Tax Identification Number (Employer Identification Number or Social Security Number) of payment recipient
- ✓ Name of person or entity that check should be made payable to

Failure to provide any of the above information may cause a delay in processing your payment.

Billing address: Requirements Division
Northwestern Mutual
P.O. Box 2950
Milwaukee, WI 53201-2950