# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

## Statements to Examiner Supplement for Life Insurance Application

| First Name | Middle Initial | Last Name | Maiden Name/Former Name | Month Day Year |
|---|---|---|---|---|
| Proposed Insured Legal Name | | | | Birth Date / / |
| Street | | City | State ZIP Code | Social Security Number |
| Legal Residence Address | | | | |

**1.** Does the Proposed Insured currently have a personal physician? ☐ **Yes** ☐ **No**
If answered "Yes," please list details below. If more space is needed, provide answers in number 10 of this application.

| Name, Address, and Telephone Number of Personal Physician | Date Last Seen | State Reason, Findings and Treatment |
|---|---|---|
| | | |

**2.** Has the Proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care provider? ☐ **Yes** ☐ **No**

**3.** Has the Proposed Insured ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:

| | Yes | No |
|---|---|---|
| **(a)** any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke? ..... | ☐ | ☐ |
| **(b)** any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath? .. | ☐ | ☐ |
| **(c)** any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder? ..... | ☐ | ☐ |
| **(d)** any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries? ..... | ☐ | ☐ |
| **(e)** any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?..... | ☐ | ☐ |
| **(f)** any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder? ..... | ☐ | ☐ |
| **(g)** any disease, or disorder of vision, or hearing? ..... | ☐ | ☐ |
| **(h)** cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder?..... | ☐ | ☐ |

**4. In the past 10 years,** has the Proposed Insured:

| | Yes | No |
|---|---|---|
| **(a)** used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider? ..... | ☐ | ☐ |
| **(b)** used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? ..... | ☐ | ☐ |
| **(c)** been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? ..... | ☐ | ☐ |

**5. In the past 12 months**, has the Proposed Insured:

| | Yes | No |
|---|---|---|
| **(a)** required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems? ..... | ☐ | ☐ |
| **(b)** received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy? | ☐ | ☐ |
| **(c)** used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? ..... | ☐ | ☐ |
| **(d)** applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?..... | ☐ | ☐ |

**6.** In the past two years, has the Proposed Insured (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? ☐ **Yes** ☐ **No**

If answered "Yes," please list details below. If more space is needed, provide answers in number 10 of this application.

| Medication Name (Copy from Pharmacy Label) | Date Last Taken | Prescribing Physician (if any) | Reason | Dosage Frequency |
|---|---|---|---|---|
| | | | | |

**7.** In the past five years, has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? ☐ **Yes** ☐ **No**

If answered "Yes," please list details below. If more space is needed, provide answers in number 10 of this application.

| Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type) | Month and Year | Duration | Degree of Recovery | Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician |
|---|---|---|---|---|
| | | | | |

**8.** Has the Proposed Insured ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? ☐ **Yes** ☐ **No** **If "Yes," to question 8, please list details below.**

| Form of Tobacco/Nicotine Replacement Therapy | Number Per Day | Date Stopped |
|---|---|---|
| | | |
| | | |

**9. Family History**

Please list details below for the Proposed Insured (If applicable)

| | Age at Death | If Living Present Health – If Deceased, Cause of Death |
|---|---|---|
| Father | | |
| Mother | | |
| Sibling 1 | | |
| Sibling 2 | | |

**10.** List details of "Yes" answers. Identify question number and provide any additional information necessary. If more space is needed, use additional sheet of paper.

_____

_____

_____

_____

All answers in this application are true and complete, to the best of my knowledge and belief, and will be relied on by United of Omaha Life Insurance Company to determine insurability. The statements and answers in the application are the basis for any policy issued by United of Omaha Life Insurance Company, and no information about them will be considered to have been given to United of Omaha Life Insurance Company unless it is stated in the application. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. This application is to be attached to and made a part of the policy.

Fraud Warning: 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: _____ _____ Date _____
City State Mo Day Yr

Witness _____ _____
Signature of Examiner Signature of Proposed Insured

# Confidential Medical Report

Mail Direct to: Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

**Applicant Name:** _____
Print Name

| 11. (a) Height (In Shoes) ft. in. | Weight (Clothed) lbs. | Males Only: Chest (Full Inspiration) in. | Chest (Forced Expiration) in. | Abdomen, at Umbilicus in. |
|---|---|---|---|---|
| | | | | |

**11. (b)** Did you weigh? ..... Yes ❑ No ❑
**(c)** Did you measure? ..... Yes ❑ No ❑
**(d)** Was blood drawn? ..... Yes ❑ No ❑

Blood Pressure (Record ALL readings.) Repeat readings if elevated.

| 12. | | | | |
|---|---|---|---|---|
| | Systolic | | | |
| | Diastolic Fourth phase | | | |
| | Fifth phase | | | |

| 13. Pulse | At Rest | After Exercise | 3 Minutes Later |
|---|---|---|---|
| Rate | | | |
| Irregularities per min. | | | |

**14.** Is appearance unhealthy or older than stated age? ..... Yes ❑ No ❑
**15.** Are there any signs of frailty (weight loss, exhaustion, weakness, slow walking speed, low physical activity, difficulty standing up or impaired balance)? ..... Yes ❑ No ❑
**16.** Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.) ..... Yes ❑ No ❑

**This section is to be completed only by a medical doctor (if required).**

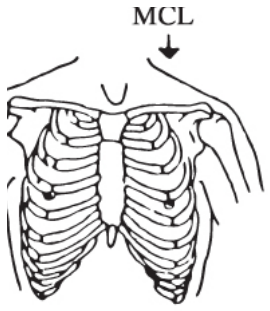
**17.** Heart: Is there any:

| Enlargement? Yes ❑ No ❑ | Dyspnea? Yes ❑ No ❑ | Murmur(s)? Yes ❑ No ❑ | Edema? Yes ❑ No ❑ |
|---|---|---|---|

(Describe below — if more than one, describe separately.)

| Location | Murmur No. 1 | Murmur No 2. |
|---|---|---|
| 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: ..... Φ
Point of greatest Intensity by: ..... O
Transmission by: ..... ➡




For comments and your impression

**18.** Is there on examination any abnormality of the following: (Circle applicable items and give details.)
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) .. Yes ❑ No ❑
(b) Skin (include scars); varicose veins, peripheral arteries, discolorations, open sores or rash? ..... Yes ❑ No ❑
(c) Lymph nodes? ..... Yes ❑ No ❑
(d) Nervous system (include reflexes, gait, paralysis)? ..... Yes ❑ No ❑
(e) Respiratory system? ..... Yes ❑ No ❑
(f) Abdomen (include scars)? ..... Yes ❑ No ❑
(g) Genitourinary system (include prostate)? ..... Yes ❑ No ❑
(h) Endocrine system (include thyroid and breasts)? ..... Yes ❑ No ❑
(i) Musculoskeletal system (include spine, joints, amputations, deformities)? ..... Yes ❑ No ❑

**19.** Did your examination reveal any condition requiring further investigation or immediate treatment? ..... Yes ❑ No ❑
(If "Yes," did you advise the Proposed Insured or refer the Proposed Insured to his or her personal physician? ..... Yes ❑ No ❑

List details of "Yes" answers to questions 14 through 19. Identify question number and use additional sheet if necessary.

Time of examination _____a.m. _____p.m. Place: ❑ Your Office ❑ Other (Explain) _____
Amount of Insurance $ _____ Name of Agent _____ Agency Name _____

EXAMINER _____ SIGNATURE _____
Please Print Name Title Title

ADDRESS _____ _____
Street City State ZIP Code Mo Day Year