❑ **Hartford Life Insurance Company**
❑ **Hartford Life and Annuity Insurance Company**
Hartford, CT 06104-2999

MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

INSTRUCTIONS FOR THE MEDICAL EXAMINER —— DETACH AND DISCARD BEFORE MAILING THE COMPLETED EXAMINATION TO THE COMPANY

1.) If you are related to the proposed insured being examined or to the agent, **PLEASE DO NOT PERFORM THIS EXAMINATION.** Please immediately advise the agent and the paramedical company so other arrangements can be made.
2.) Please perform the examination in private.
3.) PLEASE RECORD ALL INFORMATION LEGIBLY IN YOUR OWN HANDWRITING, IN BLACK INK.
4.) Please complete the Senior Exam Supplement (pages 5 and 6) on all applicants age 71 or over.
5.) Please cut the word flashcards (page 7) and arrange them in order as noted on the form prior to doing the Senior Exam Supplement.
6.) If there are any alterations or changes on pages 1, 2 or 3, the proposed insured being examined must initial them. If you have any alterations on page 4, you must initial them yourself.
7.) If you have any other medical information which may have a bearing on the insurability of this proposed insured, please list it on this exam questionnaire, or on a separate piece of paper and mail it with the examination to our Company.
8.) This examination, once begun, is the property of the Company. Please do not destroy or delay sending it to the Company
9.) Fees will be paid by the Company.

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MEDICAL EXAM QUESTIONNAIRE — APPLICATION SUPPLEMENT

PLEASE USE BLACK INK ONLY

1) Name of Proposed Insured _____ Date of Birth _____
Residence (City and State) _____

2) Primary Physician, Health Care Provider or Clinic**:**
Name _____ Address _____
_____ _____
Phone Number _____ _____
Date of Last Visit _____

Reason for Last Visit (Please include details of evaluation, treatment and/or referrals made.)

_____
_____
_____

	NOTE: GIVE DETAILS TO ALL "YES" ANSWERS ON NEXT PAGE	Yes	No
3.	Do you take any prescription, over the counter medication or herbal remedy? (If "Yes," please provide names and doses.)	☐	☐
4.	**Have you ever had, been treated for or had treatment recommended by a member of the medical profession for:**		
a.	High Blood Pressure; Heart Murmur or Heart Valve Abnormality; Chest Pain; Heart Surgery; Heart Attack; Abnormal Heart Rhythm; other Heart or Vascular Disease, Condition or Disorder; Stroke or Mini-Stroke (TIA)?	☐	☐
b.	Cancer, Tumor or other abnormal growth; Recurrent Infections; Lymph Gland Swelling or Enlargement; Immune System Disease, Human Immunodeficiency Virus (HIV) Infection, or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
c.	Diabetes or other Endocrine Disease; Condition or Disorder (e.g. thyroid, adrenal, pituitary, etc.)?	☐	☐
d.	Anemia; Blood Transfusion; Blood Vessel Disease; other Blood Disease, Condition or Disorder?	☐	☐
e.	Dizziness; Fainting or Loss of Consciousness; Alzheimer's Disease or Dementia; Epilepsy or Seizure Disorder; Brain or Spinal Cord Disorder; other Nervous System Disease; Depression, Anxiety, Stress or Panic Attacks; or other Psychological Disease, Condition or Disorder?	☐	☐
f.	Asthma, Chronic Bronchitis or Emphysema; other Lung Disease, Condition or Disorder; Sleep Apnea or Narcolepsy?	☐	☐
g.	Disease of the Esophagus, Pancreas or Stomach; Ulcerative Colitis or Crohn's Disease; Chronic Indigestion, Diarrhea or Vomiting; Hepatitis or other Disease of the Liver; Hernia, other Gastrointestinal Disease, Condition or Disorder?	☐	☐
h.	Bladder Disease; Kidney Disease; Prostate Disease; Sugar, Protein or Blood in the Urine; Breast Disease; other Genitourinary Disease, Condition or Disorder?	☐	☐
i.	Rheumatoid Arthritis, Lupus, other Connective Tissue Disease, Condition or Disorder; Arthritis, Rheumatism or other Joint Disease, Condition or Disorder ; Disease, Condition or Disorder of Bones, Back or Spine; Disease, Condition , or Disorder of Muscles, Ligaments or Tendons?	☐	☐
j.	Ear Disease or Eye Disease, Condition or Disorder?	☐	☐
k.	Chronic Fatigue, Fibromyalgia or Myalgia?	☐	☐
5.	Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	☐	☐
6.	Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	☐	☐
7.	Do you engage in regular exercise? (If "Yes," provide details).	☐	☐
8.	Have you lost 10 or more pounds in the last 6 months (not due to change in diet)?	☐	☐
9.	Have you, in the past 5 years, used any illicit drug or prescription drug that was not prescribed by a physician? (If "Yes," provide details to include treatment recommended or given.)	☐	☐
10.	Do you currently consume alcoholic beverages? (If "Yes," how many per day and per week?)	☐	☐
11.	Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	☐	☐
12.	Females only: Are you currently pregnant? (If "Yes," what is your due date?)	☐	☐
13.	Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	☐	☐

MEDICAL QUESTIONNAIRE APPLICATION SUPPLEMENT

14. Family History	Living or Deceased	Current Age or Age at Death	Health History (include age at onset)	Cause of Death
Father				
Mother				
Siblings				

DETAILS OF "YES" ANSWERS **(Please attach additional sheet if more space is needed.)**

Question Number	Diagnosis, reason for visit, treatment, medication, hospitalization, surgery, advice	Dates of onset and recovery	Name, address, and phone number of doctor, health care provider, clinic or hospital

I agree that, to the best of my knowledge and belief, the information herein is complete and true and shall be the basis for and a part of any insurance issued.

Dated at _____ **Date** _____

City **State** **Month** **Day** **Year**

Witness _____ _____

Signature of Examiner/Agent **Signature of Person examined**

Medical Examiner's Report

1) _____ _____
Height Weight
Did you weigh? Yes ❑ No ❑
Did you measure? Yes ❑ No ❑

2) Blood Pressure: take 3 readings

Systolic			
Diastolic			

3) Pulse:

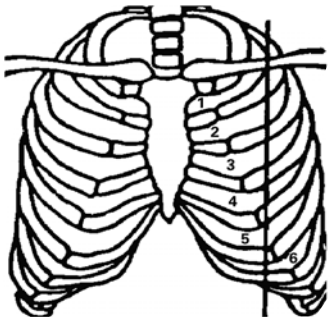
Rate	
Irregularities/mn.	

4 **) Please use the space provided to give details of the physical exam (→)**

Cardiovascular Exam — Is there any evidence of:

a.) Peripheral Vascular Disease Yes ❑ No ❑

- ❑ Abnormal or diminished pulse
  - ❑ carotid
  - ❑ other pulse
- ❑ Other signs of PVD



b.) Enlarged heart ---------- Yes ❑ No ❑

c.) Heart murmur ---------- Yes ❑ No ❑

Murmur is

❑ Constant	❑ Transmitted	❑ Systolic	❑ Apical
❑ Inconstant	❑ Localized	❑ Presystolic	❑ Basal
❑ Trace (0-I)	❑ Mild (II)	❑ Diastolic	❑ Other
		❑ Moderate (III)	❑ Loud (IV)

ShowLocation of: -- Apex by ---------- X
Area of Murmur by ---------- ◌
Point of greatest intensity by ---------- O
Transmission by ---------- →

Your impression? _____

d.) Other CV disease **(describe)**_____ Yes ❑ No ❑

5) Are there any abnormalities on examination of:

a.) Eyes	Yes ❑ No ❑	f.) Nervous System	Yes ❑ No ❑
b.) Ears	Yes ❑ No ❑	g.) Lungs	Yes ❑ No ❑
c.) Mouth, Pharynx	Yes ❑ No ❑	h.) Abdomen, Liver, Spleen, Kidney	Yes ❑ No ❑
d.) Skin, Lymph Nodes	Yes ❑ No ❑		
e.) Blood Vessels	Yes ❑ No ❑	i.) Musculoskeletal System	Yes ❑ No ❑

6) Is the person's appearance unhealthy or older than stated age? Yes ❑ No ❑

7) Do you have any information or observations relating to this person's physical or mental health that are not already recorded? **(If "yes," please give details.)** Yes ❑ No ❑

8) If female, is this person menstruating today? Yes ❑ No ❑

Details of Questions 1 - 9
USE ONLY FOR QUESTIONS ON THIS PAGE

9) Urinalysis

SPECIFIC GRAVITY	ALBUMIN	SUGAR

******SEND SPECIMEN TO LAB IN ALL CASES******

I certify that I have carefully examined_____ whose statements and signature appearing on the reverse side hereof, were made and signed in my presence and that the examination was made in private at ❑ My office, ❑ Applicant's residence, ❑ Applicant's place of business, this _____ day of _____, _____.

Examined at_____ _____ M. D. or D. O.
City State (Medical Examiner's Signature)

This examination must bear the actual date that the exam was completed and no other.

Examiner Name (Print)_____ Paramedical Co. Name _____

Address_____

Phone Number_____

Name of Agent _____ Agent's Phone Number_____

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SENIOR EXAM SUPPLEMENT

Instructions for the examiner:

PLEASE COMPLETE FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

1a.	Read aloud the instructions below to the Proposed Insured. Then read aloud each of the words on the list, one at a time, while showing the corresponding flashcard, and ask the proposed insured to make up a sentence using each word. The proposed insured may not record anything on paper. It is not necessary to record the proposed insured's response; draw a line through any word that the proposed insured cannot use in a sentence. ***In this part of the survey, I will read a word while showing the word to you. Please use each word in a sentence. The sentence may be as long or as short as you like. Later I am going to ask you to recall the words. Do you have any questions?***
1b.	Follow the same instructions as for Part a. Read aloud the instructions below. When done, place the flashcard out of sight. Note the time and allow at least 5 but not more than 15 minutes before proceeding to #6. ***Now I am going to repeat the same words as before, show you the words and again ask you to use each in a sentence. You may make up a new sentence or use the same sentence that you used before. Do you have any questions?***
2.	Read instructions to the proposed insured and record number of seconds/minutes it takes to complete the task. The proposed insured must stand up from a seated position without using the arms of the chair for help, walk 10 feet, turn around and sit down. ***Please complete this exercise: Stand up without using the arms of the chair, walk to (insert place in the room that is 10 feet away), turn around, walk back, and sit down.***
3.	Ask the proposed insured about the activities listed. Record details of answers, giving specifics of activities they do perform and reasons for ones they are unable to perform or able to perform only with assistance.
4.	Ask the proposed insured if they perform any regular exercise. Record details, including duration and frequency.
5.	Record details of any falls, including circumstances, injuries, and treatment.
6.	Read instructions to the proposed insured. Record all words, including words not on the list that the applicant recalls. DO NOT read the words to the proposed insured; this must be done from memory. AT LEAST 5 MINUTES BUT NO MORE THAN 15 MINUTES MUST HAVE ELAPSED FROM PARTS 1a AND 1b BEFORE DOING THIS ACTIVITY. ***A few minutes ago I read some words to you and you used them in sentences. Please repeat to me as many words as you can recall.***
7.	Read the instructions to the proposed insured. Allow 60 seconds for the task. Straight edge or ruler is not allowed. ***Please duplicate the following drawing.***

Upon completion of the examination, provide any additional information or observations within the details section of the answer page. Verify that the client name and date of birth, and your signature are on the Senior Supplement. Return the answer page with the other examination paperwork. Discard this instruction page and the flashcards prior to mailing any and all examination paperwork or specimens.

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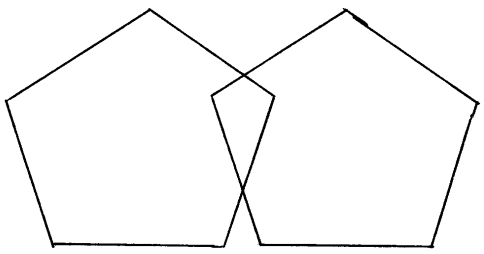
SENIOR EXAM SUPPLEMENT

PLEASE COMPLETE THE FOLLOWING FOR ALL PROPOSED INSUREDS AGE 71 AND OVER

Name of Proposed Insured:		**Date of Birth:**
1a.	Follow the instructions for question 1a. Draw a line through any word below that the proposed insured cannot use in a sentence: Book Flower Train Rug Meadow Salt Finger Park Chimney Button	**DETAILS SECTION:** Please indicate the question number and all details below.
1b.	Please repeat the task in 1a exactly, using the words in the same order. Book Flower Train Rug Meadow Salt Finger Park Chimney Button	
2.	Please ask the proposed insured to stand up, not using the arms of the chair, walk 10 feet, turn around, walk back and sit down. Record the amount of time from start to finish: _____	
3.	Is the proposed insured able to do the following without assistance? Record details at right.	
	A. Clean home, do yard work? Yes ☐ No ☐	
	B. Shop (food, clothes, etc.)? Yes ☐ No ☐	
	C. Drive, travel? Yes ☐ No ☐	
	D. Manage finances (pay bills, balance check book, etc)? Yes ☐ No ☐	
4.	Does the proposed insured engage in any type of regular exercise (walking, treadmill, running, aerobics, swimming, strength training, etc.)? Record details at right. Yes ☐ No ☐	
5.	Has the proposed insured fallen at any time in the last 2 years? Record details at right. Yes ☐ No ☐	
6.	Please ask the proposed insured to repeat as many words as they can recall from #1 above. Record responses to the right.	
7.	Please ask the proposed insured to draw the figure below in the space at the right. 	

I certify that I have personally asked all of the questions and accurately recorded responses and results.

_____ _____

Signature of examiner **Date** **Print name of examiner**

Book	**Salt**
Flower	**Finger**
Train	**Park**
Rug	**Chimney**
Meadow	**Button**