

Medical Application to the First Catholic Slovak Union of U.S.A. and Canada

TO BE FILLED OUT BY MEDICAL EXAMINER AND ANSWERED BY THE APPLICANT

A. IDENTIFICATION OF PROPOSED INSURED

1a. Full Name of Proposed Insured: 1b. Male Female
2. Address: City: State: Zip Code:
3a. Birthdate (Month, Day, Year): b. Age: c. Birthplace:

B. INSURABILITY

1. Has proposed insured ever had any disease or disorder of: (If Yes, circle condition and give details in No. 4)
2. Has proposed insured ever had any symptoms of or been affected with:
a. Nervous system, epilepsy, or paralysis?
b. The heart or blood vessels; chest pains; high or low blood pressure, rheumatic fever?
c. Stomach, liver, intestines, gall bladder?
d. The kidney, urinary, bladder, prostate?
e. Lungs; asthma; tuberculosis?
a. Cancer, tumor, diabetes, glands; or blood disorders?
b. Any serious illness, disease or injury not already listed?
c. Consultation, treatment or been examined by a physician or other practitioner or any other reason?
3. Height and weight of proposed insured: ft. in.; lbs. Give weight gained or lost in past year: Reason:
4. Give complete details of any "YES" answers to Questions B1 and 2. Give the full names and addresses of physicians seen or hospitals used within the last 5 years. Include dates, nature of disease or injury, and treatment.

Table with 4 columns: Family Record, Age, State of Health, Cause of Death. Rows for Father, Mother, Brothers/Sisters.

5b. Have any of your parents, brothers, or sisters ever had heart disease, diabetes, or mental illness? Yes No If Yes, explain:

6. In the past 5 years, have you used:
a. alcoholic beverages?
b. narcotics or drugs?
Details of Yes Answer:
7. In the past 10 years, have you been treated for alcoholism or any drug habit? Yes No If Yes, explain:

8. In the past 10 years have you been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment? Yes No If Yes, explain:

9. a. Are you now a cigarette smoker? b. Have you been a smoker and quit? c. Did, or do, you smoke more than one pack daily? d. Did you quit within the past 6 months? 6 months to 1 year ago? More than 1 year ago?

If Yes, explain:

10. Amount of life insurance in force on life of proposed insured: Other companies? \$ With FCSU? \$

11. Has proposed insured had life or health insurance rejected; rated up; postponed; modified; cancelled; or not renewed? Yes No
If Yes, explain: When? What company?

I hereby agree that the above questions and answers shall form Part II of my pending application for insurance in the First Catholic Slovak Union. I expressly waive on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder all provisions of law forbidding any physician, hospital official or employee, or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto, and I expressly authorize such persons to make such disclosures, all to the extent permitted by law.

Witness M.D. Dated this day of 20
Medical Examiner

MED-1 Signature of Applicant in Full
(Over)

MEDICAL EXAMINER'S REPORT

PART III

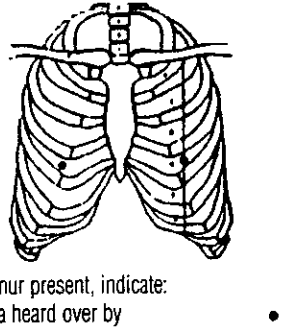
(To be completed only by a PHYSICIAN)

1. Applicant's Full Name: Mr.
Mrs.
Ms. _____

2a. Applicant's temperature: _____ b. State rate of pulse: _____

c. Is it intermittent or irregular? _____ If so, describe: _____

d. BLOOD PRESSURE (sitting position): Systolic _____
(If 145 systolic or 95 diastolic, or higher, please retake later in examination, reporting all findings.) Diastolic (5th Phase) _____

	YES	NO	
3. GENERAL Are there any indications of disorder of:			
a. Brain or Nervous System. (Test Pupillary and Patellar Reflexes. Any tremors?)	<input type="checkbox"/>	<input type="checkbox"/>	
b. Respiratory Organs (Throat, Nose, Sinuses)	<input type="checkbox"/>	<input type="checkbox"/>	
c. Glands (Thyroid, Lymph, Endocrine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
d. Blood Vessels (Arteriosclerosis, Varicosities, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
e. Skin, Muscles, Bones, Joints (Deformity, Rheumatism, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
f. Ears (Deafness, Discharge); Eyes (Vision, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
g. Musculo-Skeletal System	<input type="checkbox"/>	<input type="checkbox"/>	
			5. HEART a. Are sounds and rhythm normal? _____ b. Murmurs present? _____ Timing? _____ Transmitted? _____ c. Degree of hypertrophy? _____ d. Any dyspnea, cyanosis, etc.? _____ e. Diagnosis _____ _____ _____ Please chart per directions. →

REMARKS

6. LUNGS
Are respiratory sounds normal in all areas with no evidence of rales, dullness or other pathology? Yes No Details: _____

4. URINALYSIS
a. Specific Gravity: _____ b. Albumin? _____ c. Sugar? _____
d. Are you satisfied specimen is authentic? _____

7. ABDOMEN: Is there any evidence of tenderness or pathology developed by palpation of abdomen or pressure over liver, spleen, region of appendix, gall bladder, kidneys? _____
Is there a hernia? Yes No

8. Is there anything unfavorable about proposed insured's appearance, manner, mentality, gait, dress, or occupation, or do you know or suspect anything concerning habits or morals or other circumstances, not otherwise covered, which, in your opinion, might affect the risk adversely? _____

9. FEMALES ONLY
a. Has applicant ever had any disorder of menstruation, pregnancy, or of the female organs or breasts? Yes No If Yes, explain: _____
b. To the best of her knowledge and belief, is she now pregnant? Yes No If Yes, what month? _____

10. What in your judgment is the character of the risk: first class, good, fair, or poor? (If not first class or good, state reason for lower rating.) _____

I certify that I have carefully examined _____ whose signature is affixed to the foregoing declarations, and that the examination was made in private at { my office _____ applicant's residence _____ this _____ day of _____, 20____ applicant's place of business _____

Examined at _____ (City) _____ (State) _____ (Medical Examiner), M.D.

N.B.— THIS EXAMINATION MUST BEAR DATE OF DAY WHEN ACTUALLY MADE AND UNDER NO CIRCUMSTANCES ANY OTHER.

Medical School _____ (P.O. Address of Medical Examiner) _____
Date of graduation _____

**FOR HOME OFFICE USE ONLY
CERTIFICATION OF SUPREME MEDICAL EXAMINER**

I hereby certify that I have carefully examined and considered the within questions and answers and that I do hereby _____ this applicant for membership for benefit certification in the amount of \$ _____
(approve or reject)

REMARKS: _____ Supreme Medical Examiner

Date _____ 19 _____

IMPORTANT NOTICE TO MEDICAL EXAMINER

This report is the property of the First Catholic Slovak Union. IT MUST NOT be given to the branch officer or recommender, withdrawn or destroyed by anyone. It should be sent to the NATIONAL SECRETARY of the First Catholic Slovak Union, 6611 Rockside Road, Independence, OH 44131-2398.