



**Questions 20 thru 34 apply to the Proposed Insured only.**

20. What is the Proposed Insured's height?                      feet                      inches	
21. What is the Proposed Insured's weight?                      pounds	
22. Has the Proposed Insured gained any weight in the past year? a. If "Yes" how much ?                      lbs.      List the reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Has the Proposed Insured lost any weight in the past year? a. If "Yes" how much ?                      lbs.      List the reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Does the Proposed Insured have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide, or any hereditary disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Has the Proposed Insured sought or received counseling or treatment for alcohol or drug use, dependency, addiction or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. In the last 10 years has the Proposed Insured: a. used marijuana, cocaine, heroin, amphetamines or hallucinogens? b. used any tranquilizers, sedatives, or narcotic drugs? c. used legally prescribed drugs in excess of dosages prescribed by a physician or medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
27. In the last 10 years has the Proposed Insured ever been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. In the past 5 years has the Proposed Insured had any diagnostic studies ( X-ray, electrocardiogram, blood tests, or any other) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Has the Proposed Insured ever been diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), HIV or any other disease of the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30. In the past 10 years has the Proposed Insured ever had or been told they had: <b>(If answer is "Yes", circle all conditions that apply and provide additional details in #35 below)</b>	
a. dizziness, fainting spells, epilepsy, loss of consciousness, nervous breakdown, mental illness, strokes, or any disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. asthma, emphysema, hay fever, chronic cough, pleurisy, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. any disease or disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. stomach or duodenal ulcer, any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver, gall bladder, pancreas or spleen, nephritis, kidney stone, or any disease of the kidneys, bladder or prostate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. rheumatic fever, high blood pressure, angina pectoris, chest pain or discomfort, shortness of breath, heart murmur, swelling of legs or ankles, or any disease or disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. varicose veins, phlebitis, anemia, or any disease or disorder of the blood or glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. any tumor or disease of the breast or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. any abnormality, deformity, disease or disorder not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31. Is the Proposed Insured receiving treatment or taking medication of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Is the Proposed Insured now pregnant?    If "Yes" how long? _____      Not Applicable <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Has the Proposed Insured consulted or been treated or examined by a physician or practitioner for any cause not recorded above within the last 5 years? a. If "Yes" then when? _____ b. By whom? _____ c. Full address. _____ d. Reason for consultation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. Has the Proposed Insured smoked one or more cigarettes, cigars, or pipes, or chewed tobacco or snuff in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**35. Details and additional information related to questions 22 thru 34:**

**AGREEMENT**

I understand that all of my statements and answers shall be part of the contract of insurance when and if one is issued. I declare that all such statements and answers are, to the best of my knowledge and belief, true and complete.

**I understand that no contract of insurance will be in effect until it is issued and delivered by the PNU during the Proposed Insured's lifetime; the Proposed Insured must be in the same state of health as when the application was signed; and the first premium must have been paid.**

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION**

This Authorization is designed to comply with the HIPPA Privacy Rule

I, the Proposed Insured, hereby authorize any health plan, health care provider or health care clearinghouse, insurer, employer, or government agency that has provided payment, treatment or services to me or on my behalf, to release to the persons or entities identified in Paragraph Number 1 below, information it has about my physical or mental health, financial position or educational achievement. Paragraph Number 2 below describes the class of persons or entities hereby authorized to release personal health information about me. These persons or entities may disclose the information described in Paragraph Number 3 below.

1. The records and information will be disclosed to **The Polish National Union of America**, 1002 Pittston Avenue, Scranton, PA 18505 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about me:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, workers compensation insurer, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. (MIB)), or other health care provider, the Veterans Administration, the Social Security Administration, a consumer reporting agency, financial institution, educational institution and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of my entire medical record and any other protected health information concerning me including without limitation office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to me. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. Any financial, employment or personal information requested for insurance purposes may also be disclosed.

The purpose of this disclosure is an application for life insurance coverage or to evaluate a claim for benefits on behalf of the Proposed Insured.

The **Polish National Union of America** may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim there under; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This Authorization is good, as needed, for 30 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to the Polish National Union of America. Actions taken in reliance on this Authorization will not be affected, but no further actions will be taken in reliance on this Authorization after revocation is received by the Polish National Union of America. Revocation of this Authorization may result in the refusal to pay benefits under a policy that has been issued.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

Signature of Applicant (if other than Proposed Insured) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Member Applicant (if Proposed Insured is not a member of PNU) \_\_\_\_\_ Date \_\_\_\_\_

**DECLARATION OF AGENT**

Is the insurance applied for intended to replace any existing insurance or annuity policies now in force?  Yes  No

Agent's State License No. \_\_\_\_\_ State Licensed in \_\_\_\_\_ Telephone No. \_\_\_\_\_ Branch No. \_\_\_\_\_

Agent's name(print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Organizer's name(print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**POLISH NATIONAL UNION of AMERICA**  
**Medical Examination Report**

**Must be completed by a licensed medical professional when required.**

1. Height            ft.                    in.	Did you measure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Weight            lbs.	Did you weigh?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Pulse seated _____	Is pulse irregular?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "yes" describe and where applicable give the number of irregularities before and after exercise sufficient to increase pulse rate to 100 or more.		
4. Blood Pressure: Please record all readings. With Hypertension or if first reading is over 135 systolic or 85 diastolic take two additional readings. First Reading:    Systolic _____            Diastolic _____ Second Reading: Systolic _____            Diastolic _____		
a. Is diastolic at disappearance of all sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is diastolic at change of sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you find any evidence of past or present disease:   <b>Provide Details to "Yes" answers</b>		
a. of the heart and blood vessels? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Is there a murmur? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is there any hypertrophy? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there any arteriosclerosis? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. of the lungs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. of any of the abdominal organs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. of the skin, breasts, ears, middle ears, eyes, throat?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there any enlargement of the Thyroid? _____		
a. Is it symmetrical, asymmetrical, nodular, or diffuse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are the lymph nodes enlarged?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is there a hernia? _____		
a. Was it ever strangulated?		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there any evidence of varicose veins or ulcers? _____		
a. Do they extend above the knee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is Proposed Insured lame, maimed, or deformed?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the Proposed Insured's appearance indicate good health?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Were the circumstances under which you completed examination satisfactory?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you in any way related to the Proposed Insured or agent? _____		
a. If "Yes" to which one are you related and how?		<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are you aware of anything about the health, habits, environment, or mode of life of the Proposed Insured which might unfavorably affect insurability? _____		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you have knowledge of the Proposed Insured ever being diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), Aids-Related-Complex (ARC), HIV or any other disease of the immune system?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

**URINALYSIS**

Specific Gravity?	Reaction?
Albumin?	Test Used?
Sugar?	Test Used?
Are you satisfied that the specimen is the Proposed Insured's?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Examiner's Statement**

I have carefully examined \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Examination was made in private at my office residence of Proposed Insured place of business of Proposed Insured.

Signature of Examiner \_\_\_\_\_

Print name of Examiner \_\_\_\_\_

Examiner's address - street and number \_\_\_\_\_

city, state, zip code \_\_\_\_\_