MED UNDER 14 YRS. 6 MOS.

NEW YORK LIFE INSURANCE COMPANY

ANSWERS TO THE MEDICAL EXAMINER

forming Part II of Application when used in connection with new insurance

This examination should be made in private except that the Applicant or his representative, but not a Field Underwriter, shall be present, shall give answers for the Child and shall sign below.

For H.O. Use

1. Full Name (Please) of Child? (Print)

Date of Birth? Mo: ..... Day: ..... Yr: .....

If of school age, what is the child's grade?

Please give the following information. If answer to any question is "Yes", please give full details in item 8.

2. So far as you know, has the child ever had, or has a physician or practitioner ever been consulted in regard to the child for	Yes	No
(a) convulsions, dizziness, fainting spells, epilepsy, loss of consciousness, severe or frequent headaches, nervousness, mental illness or any other disorder of the brain or nervous system?	☐	☐
(b) rheumatic fever, St. Vitus dance, heart murmur, shortness of breath, palpitation, irregular pulse, congenital heart disease or any other disorder of the heart or blood vessels?	☐	☐
(c) tuberculosis, persistent cough, pleurisy, blood spitting, asthma, hayfever, or any other disease of the lungs or respiratory system?	☐	☐
(d) appendicitis, colitis, nervous stomach, indigestion, bleeding from the intestinal tract or any other disease of the stomach, intestines or rectum?	☐	☐
(e) nephritis; sugar, albumin, blood or pus in urine; or any other disorder of the bladder, kidney or genito-urinary system?	☐	☐
(f) any impairment or loss of sight, hearing or speech or any disorder of eyes, ears, nose or throat?	☐	☐
(g) arthritis, rheumatism or other disorder of, or injury to, bones or joints, including back or spine?	☐	☐
(h) paralysis, deformity, lameness or any other impairment of function, or loss of, hand, arm, shoulder, foot, leg or hip?	☐	☐
(i) cancer, cyst, tumor, hernia of any kind, anemia or other blood disorder; diabetes or other glandular disorder?	☐	☐

3. Has the child, so far as you know,	Yes	No
(a) ever had a surgical operation?	☐	☐
(b) ever had any condition for which a surgical operation has been recommended but not performed?	☐	☐
(c) within last 5 years, had any x-ray, electrocardiogram or other diagnostic procedure ordered by a physician or practitioner?	☐	☐
(d) within last 2 years, lived with anyone having tuberculosis?	☐	☐
(e) lost, or failed to gain, weight during the past 12 months? (If "yes", give amount, cause of weight loss or failure to gain weight, and number of months at present weight in item 8.)	☐	☐

4. Other than as stated in your answers to the preceding questions, has the child, within last 5 years, so far as you know,	Yes	No
(a) had any sickness, disease or injury?	☐	☐
(b) been admitted to a hospital or sanitarium or other similar institution?	☐	☐
(c) been examined or treated by any physician or practitioner for any reason, including routine or checkup examination?	☐	☐

5. To be answered only where the child has not reached first birthday.
   (a) What was the child's weight at birth? lbs. ____ oz.
   (b) Was the child's birth premature or abnormal in any respect? ☐ ☐

6. Do you have any reason to believe the child is not in good health at the present time? ☐ ☐

7.

Child's Family Record?	Age if Living	Condition of Health. If not "Good", give details	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these "Answers to the Medical Examiner" is correctly recorded, complete and true, and I agree that the Company, believing it to be true, shall rely and act upon it accordingly.

Dated at _____ on _____ 19 Signature of Child examined* _____

Witnessed by _____ M.D. Signature of Applicant / Applicant's Representative _____
Medical Examiner (Strike out one)

*Whenever the Child can write, he should sign in the space provided. If the Child cannot write leave this space blank.

983-530 Full-Med. Printed in U.S.A.

AUTHORIZATION TO PHYSICIANS OR PRACTITIONERS, HOSPITALS OR OTHER INSTITUTIONS

You are hereby authorized to furnish the New York Life Insurance Company with any information that you may have regarding conditions for which

_____
(Name of Child)

was under observation or treatment by you prior to the date shown below, including the history, findings and diagnosis. You are also authorized to accept a photographic copy of this authorization as if such photographic copy were the original authorization.

This is a personal request from me and your cooperation will be appreciated.

Signature of Applicant or Applicant's Representative

_____ 19

Witnessed by _____ M.D. Relationship to Child
Medical Examiner

NEW YORK LIFE INSURANCE COMPANY

ANSWERS TO THE MEDICAL EXAMINER (continued)

forming Part II of Application when used in connection with new insurance

8. Please give full details for any questions answered "Yes" in these "Answers to the Medical Examiner".

Question No.	Date(s) and Duration?	Name and address (please print) of each physician or hospital, if any; nature of illness or injury; number of attacks; severity; treatment; results; reasons and other pertinent information?

MEDICAL EXAMINER'S REPORT — NOT PART OF THE APPLICATION

101. (a) Name of the Applicant? .....

(b) Who was the third person present at examination?

.....

(If Applicant, say "Applicant"; if Applicant's representative, give name.)

(c) What is the relationship, if any, of such third person to the Child?

.....

(d) Name of the Field Underwriter as given by the Applicant (or his representative)? .....

(e) General Office with which Field Underwriter is connected?

.....

(f) How well do you know Child examined? .....

.....

(g) Are you related to the Child examined, the Applicant (or his representative), or Field Underwriter? Yes ☐ No ☐

(If "Yes", give details in item 110.)

102. Sex? Male ☐ Female ☐

103. Measurements

(a) Height? .....ft. .....in. Did you measure Child? Yes ☐ No ☐

(b) Weight? .....lbs. Did you weigh Child? Yes ☐ No ☐

IF THE ANSWER TO ANY OF QUESTIONS 104 TO 107, INCLUSIVE, IS "YES", GIVE FULL DETAILS IN ITEM 110.

	Yes	No
104. Do you find any evidence of past or present disease of		
(a) Brain or Nervous System?	☐	☐
(b) Heart or Blood Vessels?	☐	☐
(c) Lungs or other parts of the Respiratory System?	☐	☐
(d) Stomach or other Abdominal Organs?	☐	☐
(e) Genito-Urinary System?	☐	☐
(f) Ears, Eyes, Nose, or Throat? *(If there is marked impairment of vision, include corrected visual acuity for each eye in item 110. If Child is deaf, indicate if hearing aid is worn or speech affected.)*	☐	☐
(g) Bones, Joints, Glands, or Skin?	☐	☐
(h) Any other part of the body?	☐	☐
105. (a) Is there any paralysis, deformity, lameness, or loss of limb?	☐	☐
(b) Is there a hernia?	☐	☐
106. Does Child appear unhealthy, frail, anemic, or abnormal in any way?	☐	☐
107. In your opinion, is there anything about the Child's environment or mode of life which might unfavorably affect his insurability?	☐	☐

QUESTIONS 108 AND 109 TO BE ANSWERED ONLY IF THE CHILD HAS REACHED FOURTH BIRTHDAY.

108. Pulse

(a) Pulse rate? .....

(b) Is there any abnormality of rhythm? Yes ☐ No ☐
(If "Yes", give details in item 110.)

109. Urinalysis. *(If there is any abnormality of the urine or history of urinary impairment within the past five years, send portion of original specimen to the Home Office.)*

(a) Do you believe specimen is authentic? Yes ☐ No ☐

(b) Specific gravity? .....

(c) Amount of: Albumin? ..... Sugar? .....

(d) Are you sending a specimen to the Home Office? Yes ☐ No ☐

I CERTIFY that I have carefully examined..... of .....
(Print name in full) (Address)

in private, and not in the presence of any other person except as stated in Question 101 (b), at.....
(Give actual place of examination)

on.....19.....at.....o'clock A.M. / P.M. ; that I have asked each question exactly as set forth on the reverse side of this sheet and that the answers thereto are exactly as made to me, and that they have been signed in my presence. I have also reviewed all answers on this and on the reverse side, and believe them to be correctly recorded, complete and true.

.....M.D.
Signature of Examiner

Please Print or Rubber Stamp your name and address.

.....

.....

TO THE MEDICAL EXAMINER: Any erasures or alterations in this report should be initialed by you. If you prefer to do so, you may send this report, or any information which you prefer not to embody in this report, direct to Medical Department, New York Life Insurance Company, 51 Madison Avenue, New York 10, New York, without delay. If this is the first examination you have made for this Company, please indicate your medical school and date of graduation:

.....

110. Please give full details, where requested, with respect to any of the preceding questions in this "Medical Examiner's Report". This space may also be used for any additional remarks pertinent to this Report.

Question No.	Details and Additional Remarks