TRANSAMERICA OCCIDENTAL LIFE

Transamerica Occidental Life Insurance Company
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Application Part 2
Non-Medical Health History

MPN 1-303

Complete a separate Part 2 for each person applying for coverage. **File #** _____

1. **PROPOSED INSURED'S NAME:** *(First, M.I., Last)*	**DATE OF BIRTH**	**SOCIAL SECURITY NO.**
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2. **NAME AND ADDRESS OF YOUR PERSONAL PHYSICIAN:**	3. **DATE AND REASON LAST CONSULTED:** 4. **CURRENT MEDICATION OR TREATMENT:**

5. **HEIGHT:**	**WEIGHT:**	Has your weight changed more than 15 pounds in the past year? ☐ Yes ☐ No If "Yes", reason:

For all "Yes" answers, provide full details on Page 2.

6. **WITHIN THE PAST FIVE YEARS HAVE YOU:**

a. Consulted, been examined or been treated by any physician or practitioner? ☐ Yes ☐ No
b. Had an X-ray, electrocardiogram or any laboratory test or other diagnostic study other than an AIDS-related test? ☐ Yes ☐ No
c. Had observation or treatment at a clinic, hospital or other medical facility? ☐ Yes ☐ No
d. Had or been advised to have a surgical procedure? ☐ Yes ☐ No
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? ☐ Yes ☐ No
f. Had any injury requiring treatment? ☐ Yes ☐ No
g. Used nicotine in any form? *(Indicate type, frequency and date last used on Page 2)* ☐ Yes ☐ No

7. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**

a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood? ☐ Yes ☐ No
c. Asthma, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs, bronchial tubes, or respiratory system? ☐ Yes ☐ No
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? ☐ Yes ☐ No
e. Sugar, protein, or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts or reproductive system? ☐ Yes ☐ No
f. Diabetes or any disease or abnormality of the thyroid, adrenal or other glands? ☐ Yes ☐ No
g. Arthritis, gout, back trouble, any disease or abnormality of the joints, muscles or bones? ☐ Yes ☐ No
h. Any disease or abnormality of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No
i. Cancer, tumor, polyp, or cyst? ☐ Yes ☐ No
j. Any physical deformity or amputation? ☐ Yes ☐ No
k. Anxiety, depression, or any psychiatric or emotional condition or disorder? ☐ Yes ☐ No
l. An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No

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8. **WITHIN THE PAST TEN YEARS, HAVE YOU USED:**

a. Amphetamines, barbiturates, sedatives or morphine or any other narcotic drug except as prescribed by a physician? . . . . . ☐ Yes ☐ No

b. Cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, PCP, LSD, or any other hallucinogenic drug? . . . . . ☐ Yes ☐ No

9. a. Have your parents, brothers, sisters or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? . . . . . ☐ Yes ☐ No

b. Have you ever been treated or counseled for the use of alcohol or drugs or joined an organization for alcohol or drug dependence or abuse? . . . . . ☐ Yes ☐ No

c. Has any application for insurance on your life ever been declined, withdrawn, postponed, rated, or modified in any way? . . . . . ☐ Yes ☐ No

d. Are you now pregnant? . . . . . ☐ Yes ☐ No

Question Number	Give complete details of all "Yes" answers to questions 6-9, including all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals and attending physicians. If additional space is required, attach sheet of paper, signed, dated and witnessed.

10. **FAMILY HISTORY:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers #				
Sisters #				

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on this _____ day of _____ , 20_____

AGENT'S STATEMENT: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

X _____
Signature of Witness/Agent/Registered Representative

X _____
Signature of Proposed Insured *(of parent or legal guardian if Proposed Insured is a minor)*