LLOYD'S

PFS SPECIALTY RISK UNDERWRITERS

Disability Insurance Application for Physicians

PART II – Medical Examination *(Covered Individual's answers must be recorded by Medical Examiner with no one else present.)*

COVERED INDIVIDUAL *(First, M.I., Last)*	DATE OF BIRTH *(Mo., Day, Yr.)*

1. Have you ever been diagnosed by a physician for, or been treated for, or experienced any of the following:	Yes	No	Details of "Yes" answers: Identify question number, circle applicable items. Include diagnosis, dates, duration, and names of all attending physicians and medical facilities.
a. Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels?	☐	☐	
b. Ulcers, colitis, jaundice or other disease of the stomach, liver, intestines, or gallbladder?	☐	☐	
c. Sugar, albumin, blood or pus in the urine; venereal disease; disorder of the kidney or bladder?	☐	☐	
d. Seizures, fainting, dizziness, epilepsy, stroke or paralysis?	☐	☐	
e. Nervous, mental or emotional disorder or received counseling for anxiety, depression, nervousness, stress, mental or nervous disorder or any other emotional problem?	☐	☐	
f. Any tumor, cancer, cysts or any disorder of the lymph glands?	☐	☐	
g. Arthritis, osteoarthritis, gout, recurrent back pain, sciatica, neuritis, or any disorder of the back, spine, nerves, muscles, bones or joints?	☐	☐	
h. Diabetes, thyroid or other endocrine or glandular disorder?	☐	☐	
i. Anemia or any other blood disorder?	☐	☐	
j. Asthma, emphysema, shortness of breath or any disorder of the respiratory system?	☐	☐	
k. Disorder of the eyes, ears, nose or throat?	☐	☐	
l. Drug or alcohol abuse or been advised to limit your use of alcohol or addictive substances?	☐	☐	
m. Any physical abnormality or deformity?	☐	☐	
n. Allergies or skin disorder?	☐	☐	
2. Are you now under observation or treatment?	☐	☐	
3. Have you ever been diagnosed as having or been treated by a Physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐	
4. Other than the above, have you within the past 5 years:			
a. Had any mental or physical disorder not listed above?	☐	☐	
b. Had a check-up, electrocardiogram, x-ray, blood test or diagnostic test?	☐	☐	
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐	
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐	
e. In your medical opinion, been aware or are you currently aware of any personal condition or symptom which will require medical treatment?	☐	☐	
5. Have you ever requested or received benefits or payment because of an injury, sickness or disability?	☐	☐	
6. Have you used tobacco in any form within the past 12 months? *If "Yes," describe frequency and type of tobacco used.*	☐	☐	
7. Family History: Diabetes, cancer, high blood pressure, mental illness, suicide or heart disease?			

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters			
No. Living			
No. Dead			

8. Have you ever had any disorder of the reproductive organs (testicles, prostate, breasts, ovaries, etc.)? ☐ Yes ☐ No

9a. Are you currently pregnant? ☐ Yes ☐ No

b. If so, have there been any complications with this pregnancy or any other pregnancy? ☐ Yes ☐ No

10a. Name and address of your personal physician:

b. Date and reason last consulted:

c. What treatment was given or medicine prescribed?

I hereby declare that the statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that a copy of this Part II shall be attached to and form a part of any policy issued.

Dated on _____

Witness (Medical Examiner) _____ Covered Individual _____

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MEDICAL EXAMINER'S REPORT

Males Only:

DETAILS OF "YES" ANSWERS 11-19 (Identify Item)

11a. Height (in shoes)	Weight (in clothes)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen (At Umbilicus)
ft. in.	lbs.	in.	in.	in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Any change in weight in the past year? ☐ Yes ☐ No

d. Is appearance unhealthy or older than stated? ☐ Yes ☐ No

12. Blood pressure (If above 140/90 report additional readings below):

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

13. PULSE	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

14. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

If more than one murmur describe each separately.

Constant ☐ Location:

Inconstant ☐

Transmitted ☐ Apex:

Localized ☐

Murmur Area:

Systolic ☐ Point of greatest intensity:

Presystolic ☐

Diastolic ☐

Soft (Gr. 1-2) ☐ Transmission:

Mod (Gr. 3-4) ☐

Loud (Gr. 5-6) ☐

After exercise:

Increased ☐

Absent ☐

Unchanged ☐

Decreased ☐

18a. Are you related to the Applicant? ☐ Yes ☐ No

b. Are you associated with the Applicant in any business or financial venture? ☐ Yes ☐ No

19. Have you any reason to believe that the Applicant uses or has used alcoholic beverages or drugs to excess? ☐ Yes ☐ No

20. **URINALYSIS**

Hours Voided	Albumin	Sugar
☐ A.M. ☐ P.M.		

Always send a urine specimen and blood sample (if applicable) to appropriate LAB.

15. Is there on examination any abnormality of the following:	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (include scars), lymph nodes, veins or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Genitalia (males only)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐

16a. Are there any hernias?

b. Are there any hemorrhoids?

17. Are you aware of any additional medical history: Signs, symptoms or laboratory findings? (A confidential report may be sent to the Medical Director.)

21. If you do any of the following, please Indicate:

☐ Blood Profile } SENT TO LAB
☐ Urine Speciman }

☐ PA Chest X-ray } TO HOME OFFICE
☐ ECG } ON VOUCHER
☐ Other

PLEASE PRINT

Dated (Mo., Day, Yr.)	MEDICAL EXAMINER	
Name of Agent	Examiner's P.O. Box	Examiner #:

Disability Insurance Application for Physicians

AUTHORIZATION

The purpose of this authorization is to allow Pro Financial Services, LLC/Lloyd's of London to determine your eligibility for life or health insurance coverage or a claim for benefits under a life or health policy.

I AUTHORIZE any medical professional, hospital, medical care institution, insurer, Medical Information Bureau, Inc., consumer reporting agency, Social Security Administration, employer, or other person having records or knowledge of me or my family members' physical or mental health, or any other information bearing on my (our) insurability, to give Pro Financial Services, LLC and its reinsurers, or any consumer reporting agency acting on their behalf, any such information, this shall include all information about my (our) medical history, diagnosis, treatment, and prognosis including information regarding alcohol or drug abuse.

I AUTHORIZE Pro Financial Services, LLC/ Lloyd's of London to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorder, or the presence of medication, drugs, or nicotine.

I UNDERSTAND THAT my (our) medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I (we) may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of two years after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such a report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I do ☐ do not ☐ request to be interviewed.

Signed on _____, _____ _____

(Mo., Day, Yr.) Signature of Covered Individual

Disability Insurance Application for Physicians

MEDICAL FEE VOUCHER (Please Print)

Applicant Name (First, M.I., Last)	
Date of Birth (Mo., Day, Yr.)	
Examiner or Facility	
Street Address	
City, State, Zip Code	
Tax Payor	
Date of Examination	

Applicable Fees

Exam	
EKG	
X-Ray	
Urinalysis	
Blood Chemistry	
Other	
Total	

Mail Medical Voucher and Examination to: Pro Financial Services, LLC
500 West Madison Street, Suite 2660
Chicago, Illinois 60661

Payment will be made from the Medical Voucher submitted. DO NOT ACCEPT PAYMENT FROM ANY OTHER SOURCE.

Please use the portion below for confidential information.