

SUPPLEMENTAL STROKE/HEMORRHAGE QUESTIONNAIRE B

This application supplements the application on Proposed Annuitant _____,
dated (MM/DD/YYYY) _____.

"Treated" or "Treatment" as used in the health questions that follow is defined as "the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing".

Have you been diagnosed or treated by a member of the medical profession for any form of brain hemorrhage or stroke (cerebral vascular accident)? Yes No

When did the first stroke/hemorrhage occur? _____ (month/year)

Have you been diagnosed with or treated for any additional strokes/hemorrhage? Yes No

If yes, when did the last stroke/hemorrhage occur? _____ (month/year)

Have you been advised by a member of the medical profession that you have completely recovered? Yes No

Do you have any of the following as a result of your stroke/hemorrhage? (Please check appropriate box or boxes.)

- speech impairment
- vision impairment
- residual paralysis of an arm
- residual paralysis of a leg
- other

In respect to your mobility, as a result of your stroke/hemorrhage are you:

- fully independent
- able to walk only with assistance e.g. cane, walker
- wheelchair bound
- in need of daily nursing care
- bedridden

Signatures

Proposed Insured Signature

Applicant / Owner (if other than Proposed Insured)

Witness – Licensed Agent Signature

Signed at _____, on _____
City/State Month / Day / Year

SUPPLEMENTAL CANCER QUESTIONNAIRE C

This application supplements the application on Proposed Annuitant _____,
dated (MM/DD/YYYY) _____.

"Treated" or "Treatment" as used in the health questions that follow is defined as "the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing".

Have you been diagnosed or treated by a member of the medical profession for any form of cancer, leukemia, Hodgkin's disease, lymphoma, brain or spinal tumor? Yes No

If yes, what type of cancer did you have and which part of the body was involved? _____

Have you been told by a member of the medical profession that your cancer was: (Please check, if yes.)

- early cancer (carcinoma in situ) advanced cancer
 localized cancer not known or none of the above

When was the cancer first diagnosed? _____ (month/year)

Are you under treatment from a specialist consultant (e.g. oncologist, hematologist)? Yes No

Have you been admitted to a hospital for this condition? Yes No

If yes, when were you first admitted? _____ (month/year)

Have you been diagnosed or treated by a member of the medical profession for any recurrence of the cancer? Yes No
If yes, when was the last recurrence of the cancer? _____ (month/year)

Have you been diagnosed or treated by a member of the medical profession for cancer that spread into other parts of the body? Yes No

If yes, has it spread into the following areas: (Please check appropriate box or boxes.)

- lymph nodes bones
 liver other parts of the body
 lung

With special reference to leukemia, Hodgkin's disease or lymphoma, has it spread to any of the following: (Please check all appropriate boxes.)

- lymph nodes in the upper body (chest)
 lymph nodes in the lower body (abdomen, groin)
 spleen
 other parts of the body (e.g. brain, liver)

Generally, in respect to your condition, what treatment did you receive:

- surgery If yes, date of last treatment _____ (month/year)
 radio therapy If yes, date of last treatment _____ (month/year)
 chemo therapy If yes, date of last treatment _____ (month/year)
 bone marrow transplant If yes, date of last treatment _____ (month/year)
 other treatment, (please specify _____)

Signatures

Proposed Insured Signature

Applicant / Owner (if other than Proposed Insured)

Witness – Licensed Agent Signature

Signed at _____, on _____
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SUPPLEMENTAL DIABETES QUESTIONNAIRE D

This application supplements the application on Proposed Annuitant _____,
dated (MM/DD/YYYY) _____.

"Treated" or "Treatment" as used in the health questions that follow is defined as "the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing".

Do you have type I or type II diabetes that has been diagnosed or treated by a member of the medical profession? Yes No

When was the diabetes first diagnosed? _____ (month/year)

What is your type of treatment:

diet oral prescription medication insulin

How often do you monitor your blood glucose yourself?

- I don't monitor my blood glucose myself
- once a week or longer
- 2-3 times per week
- once a day
- 2-3 times per day
- more than 3 times per day

Have you been admitted to a hospital due to your diabetes? Yes No

If yes, when were you last admitted to a hospital due to your diabetes? _____ (month/year)

Do you have any of the following conditions as a result of your diabetes: (Please check all that apply.)

- problem with your eyes (retinopathy)
- proteinuria (albumin in urine) or kidney problem (nephropathy)
- raised blood pressure
- loss of sensation (in feet and toes) (neuropathy)
- none of the above

Signatures

_____ Proposed Insured Signature	_____ Applicant / Owner (if other than Proposed Insured)
_____ Witness – Licensed Agent Signature	Signed at _____, on _____ City/State Month / Day / Year

SUPPLEMENTAL ALZHEIMER'S/PARKINSON'S/DEMENTIA QUESTIONNAIRE E

This application supplements the application on Proposed Annuitant _____,
dated (MM/DD/YYYY) _____.

"Treated" or "Treatment" as used in the health questions that follow is defined as "the prescribing of any medication or course of action, undergoing or being advised to undergo any diagnostic testing".

Have you been diagnosed or treated by a member of the medical profession for Alzheimer's disease, Parkinson's disease or Dementia? Yes No

If YES, please check the appropriate box or boxes.

- Alzheimer's
- Parkinson's
- Dementia

When was this condition diagnosed? _____ (month/year)

Have you been admitted to a hospital for this condition or for complications such as pneumonia or bed sores? Yes No

If yes, when were you last admitted to hospital for this condition? _____ (month/year)

How many different types of prescription medications do you take on a daily basis for your condition?

- none
- 1 - 2 drugs
- 3 or more drugs

In respect to your mobility, as a result of your condition are you:

- fully independent
- able to walk only with assistance e.g. cane, walker
- wheelchair bound
- in need of daily nursing care
- bedridden

Are any of the following also present:

- previous stroke
- pressure sores
- seizures
- a heart condition
- none of the above

Signatures

Proposed Insured Signature

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Witness - Licensed Agent Signature

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City/State Month / Day / Year