PART 2

NON-MEDICAL APPLICATION FOR:

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT STREET • P.O. BOX 1625 • BINGHAMTON, NY 13902-1625

1. A. Name of Proposed Insured_____ B. Date of Birth_____

2. A. What is your height? ___ ft. ___ in. B. What is your weight? ___ lbs. C. Have you lost weight in past year? ☐ Yes ☐ No. If "Yes," how much? ___ lbs. D. Cause?_____

3. A. Who is the doctor who can give us the most complete and up to date information concerning your present health? Name _____ Address_____ If none, check ☐
   B. When was he last consulted?_____ Why?_____
   C. What treatment was given or medication prescribed?_____ If none, check ☐

Answer by checking (✓) "Yes" or "No." Underscore items to which "Yes" answers apply.

Please give details of all "Yes" answers. Ques. No.; when (each instance), length of illness, after effects, names and addresses of physicians and hospitals (Ques. 4 through 7); why, when, and name of company (Ques. 10).

	Yes	No
4. Have you been diagnosed by a member of the medical profession as having had or have you received medical treatment for:		
A. Disorder of eyes, ears, nose or throat?	☐	☐
B. Fainting, convulsions, paralysis, stroke, psychiatric or neurological disorder?	☐	☐
C. Allergies, emphysema, bronchitis or any disorder of the lungs?	☐	☐
D. Any heart or circulatory condition, high blood pressure or chest pain?	☐	☐
E. Any gastrointestinal, liver or gall-bladder disorder?	☐	☐
F. Venereal disease or any disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
G. Diabetes, thyroid or other endocrine disorder?	☐	☐
H. Arthritis, gout or disorder of the muscles or bones?	☐	☐
I. Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐	☐
J. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐
K. Anemia or other disorder of the blood?	☐	☐
5. Are you now under observation or taking medication or treatment?	☐	☐
6. Do you have any doctor's visit or medical care scheduled?	☐	☐
7. Other than as disclosed above, have you within the past 5 years:		
A. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
B. Been advised by a member of the medical profession to have any diagnostic test, hospitalization, treatment, or surgery which has not been completed?	☐	☐
8. Have you ever used heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines or other similar drugs except as prescribed by a physician?	☐	☐
9. Have you ever received treatment, advice or counseling from a physician or other practitioner relating to the use of drugs or the use of alcoholic beverages? (If "Yes," give name and address of physician or practitioner and date of last visit.)	☐	☐
10. Have you:		
A. Applied for or been examined for life or health insurance within the past year?	☐	☐
B. Ever been declined, postponed or rated up for life or health insurance?	☐	☐
11. Have you smoked or used any tobacco product within the last 12 months?	☐	☐

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief. Signed in my presence.

Date	Signature of Agent	Signature of Proposed Insured