

For Physicians

Part IIA OF APPLICATION TO PRO FINANCIAL SERVICES, INC.

1a. Name (<i>First, M.I., Last</i>)		4. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Date of Birth (<i>Mo., Day, Yr.</i>)	c. Sex <input type="checkbox"/> M <input type="checkbox"/> F	<i>If "Yes," provide details in #7.</i>	
2. Have you ever received treatment for or lost time from work due to drug or alcohol abuse, or been advised to limit your use of alcohol or addictive substances? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes," describe frequency and quantity in #7.</i>		5. Have you had any change in weight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes," provide details in #7.</i>	
3. Within the past 10 years, have you used cocaine, marijuana, barbiturates, heroin, or any narcotic drug except as prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes," please describe the circumstances including type of drugs used and the amount, frequency and date last used in #7.</i>		6. What is your exact height and weight? ft. in. lbs.	

7. Details of "Yes" answers to questions 2-5. Identify question number.

8. Have you ever had any indication of, or been treated for: <i>If "Yes," complete Number 11 below.</i>	Yes	No
a. Chest pain, high blood pressure, heart disease or other disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
b. Ulcers, colitis, disease of the stomach, liver, intestines, gallbladder, kidney or urinary bladder?	<input type="checkbox"/>	<input type="checkbox"/>
c. Seizures, fainting, dizziness, epilepsy, stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
d. Nervous, mental, or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Any tumor, cancer, cysts or any disorder of lymph glands?	<input type="checkbox"/>	<input type="checkbox"/>
f. Arthritis, osteoarthritis, gout, recurrent back pain or any disorder of back, spine, muscles, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Anemia or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Asthma, emphysema, shortness of breath or any disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
k. Drug or alcohol abuse or been advised to limit your use of alcohol or addictive substances?	<input type="checkbox"/>	<input type="checkbox"/>
l. Any disorder of the reproductive organs (testicles, prostate, breasts, ovaries, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
m. Any physical abnormality or deformity?	<input type="checkbox"/>	<input type="checkbox"/>
n. Allergies or skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
o. Any history of diabetes, cancer or heart disease in parents, brothers, or sisters?	<input type="checkbox"/>	<input type="checkbox"/>
p. Any other condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>

9. a. Have you ever been diagnosed by a member of the medical profession as having AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had swollen lymph glands, loss of appetite, weight loss, fever, oral thrush, rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause? <i>If "Yes," complete number 11.</i>	<input type="checkbox"/>	<input type="checkbox"/>

10. Within the past 5 years have you:		
a. Had a check-up, electrocardiogram, x-ray, blood test or diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had or been advised to have any diagnostic test, hospitalization, or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in a hospital, sanatorium or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. In your medical opinion been aware or are you currently aware of any personal condition or symptom which will require medical treatment in the future?	<input type="checkbox"/>	<input type="checkbox"/>

11. If any questions in 8-10 are answered "Yes," indicate the question number (e.g., 8d) and give **complete** details.

No.	Details or Reason and any current medication	Onset Date	Duration	Result	Name and Address of all Physicians

12. When and for what reason did you last consult a physician? (Give details below)

13. If, in the opinion of the Company, a medical examination by a duly appointed Medical Examiner is necessary as further evidence of insurability, do you agree to take such examination? Yes No

I have read the above questions and answers and declare that in my opinion as a qualified medical doctor they are complete and true to the best of my knowledge and belief. I agree a) that this Part IIA Application and the Disability Insurance Application shall form a part of any policy issued, and b) that no agent of the Company shall have the authority to waive a complete answer to any question in this Application, make or alter any contract, or waive any of the Company's other rights or requirements.

Dated on _____

INSTRUCTIONS FOR COMPLETION:

1. The proposed insured or the Representative in the presence of the proposed insured, must complete Part IIA in handwriting. Please use black or dark blue ink (as a photocopy of the application becomes part of the policy).
2. All questions must be answered fully. Amendments will be necessary to complete details of unanswered questions
3. Name and addresses of doctors and medical facilities must be legible and complete.