PART II **Check the appropriate company.** **Case/Policy #** _____ **1**

Paramedical/ Medical Exam

❑ **Brighthouse Life Insurance Company** ❑ **New England Life Insurance Company**

The Company indicated above is referred to as "the Company."

The questions below are directed to the person to be examined. Record ONLY this person's answers in the spaces below.

1. Name of Proposed Insured _____ LAST _____ FIRST _____ MIDDLE _____ Date of Birth MONTH/DAY/YEAR

2. Tobacco Use – Indicate date last smoked/used:
Cigarette _____ ❑ **Never** Smokeless Tobacco _____ ❑ **Never** Cigar/Pipe _____ ❑ **Never**
Nicotine Substitute (i.e., Patch, Gum, etc.) _____ ❑ **Never** Amount/Frequency _____ How Long _____ yrs.

3. Please provide name of doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health. If **None**, check ❑.
Physician Name _____ Name of Practice/Clinic _____
Street _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____ Date Last Consulted MONTH/DAY/YEAR
Reason _____
Findings, treatment given, medication prescribed. If **None**, check ❑. _____
_____
Reasons, findings, earlier consultations past 5 years _____
_____

4. Height _____ ft. _____ in. Weight _____ lbs. Change in weight in past 12 months? ❑ **Yes** ❑ **No**
If **Yes**, Pounds lost _____ Pounds gained _____ Reason _____

5. Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:

a) High blood pressure; chest pain; heart attack; irregular heartbeat; peripheral vascular disease; or any other disease or disorder of the heart or circulatory system (blood vessels)? ❑ **Yes** ❑ **No**

b) Asthma; bronchitis; pneumonia; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system? ❑ **Yes** ❑ **No**

c) Seizures; stroke; paralysis; Alzheimer's disease or other form of dementia; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder of the brain or nervous system? ❑ **Yes** ❑ **No**

d) Ulcers; colitis; hepatitis; cirrhosis; pancreatitis; or any other disease or disorder of: the liver; pancreas; gallbladder; esophagus; stomach; spleen; or intestines? ❑ **Yes** ❑ **No**

e) Any disease or disorder of: the breasts; reproductive organs; or the genitourinary system, including but not limited to: the kidney; bladder; or prostate; or blood, protein or pus in the urine? ❑ **Yes** ❑ **No**

f) Diabetes; thyroid disorder; elevated cholesterol or other lipid disorder; or any other endocrine disease or disorder? ❑ **Yes** ❑ **No**

g) Arthritis; gout; osteoporosis; or other disease or disorder of the: muscles; bones; spine (discs, back, neck); or joints? ❑ **Yes** ❑ **No**

h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin? ❑ **Yes** ❑ **No**

i) Anemia; leukemia; or any other disease or disorder of the blood or lymph glands? ❑ **Yes** ❑ **No**

j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? ❑ **Yes** ❑ **No**

k) Any disease or disorder of the eyes, ears, nose, or throat? ❑ **Yes** ❑ **No**

Details: List question number. Give: dates; duration/ description of condition; diagnosis; treatment; physician, practitioner or health facility names and addresses.

Details (Continued):

6. Are you now, or within the past year, taking medication or receiving treatment? (Including over the counter medications, vitamins, herbal supplements, alternative therapies, etc.) ❑ **Yes** ❑ **No**

7. Do you have any doctor's visits, medical tests, medical care, or surgery scheduled for the next six months? ❑ **Yes** ❑ **No**

8. Other than the above, during the past five years have you had any:

a) Checkup; consultations; electrocardiogram; chest x-ray; or other medical test? ❑ **Yes** ❑ **No**

b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication? ❑ **Yes** ❑ **No**

9. Have you:

a) ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ❑ **Yes** ❑ **No**

b) ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) virus or for antibodies to the AIDS (HIV) virus? ❑ **Yes** ❑ **No**

10. a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? ❑ **Yes** ❑ **No**

b) Have you ever received treatment from a physician, practitioner, health facility or counselor regarding the use of alcohol, or the use of drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? ❑ **Yes** ❑ **No**

11. Do you exercise? ❑ **Yes** ❑ **No** Type _____ How often?_____

12. Are you now pregnant? ❑ **Yes** ❑ **No** If **Yes**, estimated date of delivery? _____

13. Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer? (If **Yes**, indicate below.) ❑ **Yes** ❑ **No**

Relationship to Proposed Insured:	Age(s) if living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

14. a) Do you currently use any assisted devices such as: a walker; wheelchair; long leg braces; cane; or crutches? ❑ **Yes** ❑ **No**

b) Do you need any assistance or supervision with any or all of the following activities: eating; bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence or taking medication? ❑ **Yes** ❑ **No**

If **Yes**, provide details above.

I have read the answers to questions 2-14 before signing. They correctly reflect the answers given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Signature of Proposed Insured _____ (PARENT OR GUARDIAN IF UNDER 18) Date _____ MONTH/DAY/YEAR

Witness to Signature _____ City and State _____

Report of Paramedical/Medical Examiner

Section 1 Complete for All Exams

1. Name of person examined _____ Date/Time of exam _____

2. Sex: **M** ❑ **F** ❑ If female, was Proposed Insured menstruating on date of this examination? **Yes** ❑ **No** ❑

3. Height (in shoes) _____ ft. _____ in. Weight (clothed) _____ lbs.
Chest (full inspiration) Males _____ in. Chest (forced expiration) Males _____ in. Abdomen (at umbilicus) Males _____ in.
Did you measure? **Yes** ❑ **No** ❑ Did you weigh? **Yes** ❑ **No** ❑

4. Blood Pressure: Sitting Systolic/Diastolic – 5th phase _____/_____
If systolic over 140 or diastolic over 90, repeat later in exam _____/_____ _____/_____

5. Pulse At Rest: Rate (per min.) _____ Irregularities (per min.) _____

6. Is appearance unhealthy or older than stated age? **Yes** ❑ **No** ❑

7. Urinalysis: Protein: **Positive** ❑ **Negative** ❑ Sugar: **Positive** ❑ **Negative** ❑
Is blood also being sent to lab? **Yes** ❑ **No** ❑ ECG done? **Yes** ❑ **No** ❑

Urine samples must be sent to lab for analysis

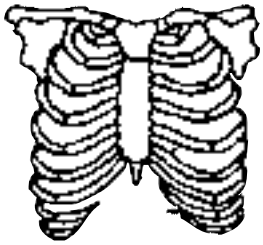
Place Kit Sticker Here

Section 2 Complete for Physician Exam Only

8. Heart: Is there any: a) Enlargement? ❑ **Yes** ❑ **No** c) Dyspnea? ❑ **Yes** ❑ **No**
b) Murmur(s)? (If **Yes**, complete below) ❑ **Yes** ❑ **No** d) Edema? ❑ **Yes** ❑ **No**

	Murmur 1	Murmur 2
Location (Apical, Aortic, Pulmonic, Parasternal)		
Timing (Systolic, Presystolic, Diastolic)		
Quality (Coarse, Blowing, Rumbling, Musical)		
Loudness (Grade 1-6)		
Constant (Yes or No)		
Transmitted (Yes or No)		
After Exercise (Increased, Absent, Unchanged, Decreased)		

Indicate:
Apex by: X
Murmur area by: □
Point of greatest intensity by: O
Transmission by: →



9. Is there on examination any abnormality of the following?

a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) ❑ **Yes** ❑ **No**
b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries? ❑ **Yes** ❑ **No**
c) Nervous system (include reflexes, gait, and paralysis)? ❑ **Yes** ❑ **No**
d) Respiratory system? ❑ **Yes** ❑ **No**
e) Abdomen (describe scars, liver enlargement)? ❑ **Yes** ❑ **No**
f) Genitourinary system? ❑ **Yes** ❑ **No**
g) Endocrine system (include thyroid)? ❑ **Yes** ❑ **No**
h) Musculoskeletal system (include spine, joints, amputations, and deformities)? ❑ **Yes** ❑ **No**

10. Are there any hernias? ❑ **Yes** ❑ **No**

11. Are you aware of additional medical history? ❑ **Yes** ❑ **No**

12. Are you the personal physician of the applicant? ❑ **Yes** ❑ **No**

Details for answers to questions 8-12:

13. Please provide your overall clinical impression of Proposed Insured:

Section 3 • Complete for Proposed Insureds Age 70 and Over • Complete for Proposed Insureds Age 65 and Over who are applying for the Long-Term Care Acceleration of Death Benefit Rider

1. Ask the Proposed Insured if he/she:

a) Has a history of falls within the last year. ❑ **Yes** ❑ **No**
If **Yes**, provide details of all falls (including how many, dates, reason, and treatment).
_____

b) Lives with another person. ❑ **Yes** ❑ **No**
If **Yes**, relationship to Proposed Insured?_____
How often do you visit with family/friends? _____
Lives in an assisted living facility or other facility with services on site? ❑ **Yes** ❑ **No**

c) Drives. ❑ **Yes** ❑ **No**
If **Yes**, does the Proposed Insured have a handicap license plate or sticker? ❑ **Yes** ❑ **No**
If **No**, when and why did the Proposed Insured stop? _____

d) Works, volunteers, travels, and/or has hobbies. ❑ **Yes** ❑ **No**
If **Yes**, provide details (including type of activity and how often). _____
_____

e) Needs assistance with any or all of the following activities: (Check only those that apply:) ❑ **Yes** ❑ **No**
❑ Cooking/Meal Preparation ❑ House Cleaning ❑ Laundry
❑ Shopping ❑ Handling Finances ❑ Using the Telephone
If **Yes**, provide details. _____
_____

2. Point to three objects and ask the Proposed Insured to tell you what they are and indicate that you are going to ask them to recall these later. Record the three objects exactly as the Proposed Insured states them.
_____

3. Ask the Proposed Insured to stand up, walk at least 10 feet, turn around, walk back, and sit down in the same place. Observe and record the performance (Comment on speed and steadiness; note any hesitancy, limping, unsteadiness, etc.).
_____
_____

4. Please have the Proposed Insured draw a clock reading 11:10. →
If more space is required for the drawing, please attach a separate page.

5. Now ask the Proposed Insured to remember the three objects from earlier. Ask him/her to restate them. Please record his/her exact response here.
_____

EXAMINER'S ASSESSMENT

1. If exam was conducted in the home, describe the Proposed Insured's living situation and possible safety issues:
home – with stairs; home – one level; clean appearance; loose carpeting; untidy/disrepair; cluttered hallways/sidewalks; etc.
_____

2. Describe the Proposed Insured's appearance:
average build; well groomed; appears healthy; slender build; poorly groomed; appears fragile; obese; poor dentition; etc.
_____

Section 4 Complete for All Exams

Place of exam: ❑ Examiner's Office ❑ Proposed Insured's Residence ❑ Proposed Insured's Business ❑ Other _____
City/State _____
Agent/Broker_____ Branch/District# or Agency Name _____
Signature of Paramedical/Physician Examiner _____
Printed Name of Examiner _____ TIN of Examiner_____
Address of Examiner _____ Vendor Name _____
Was the exam conducted with a translator? ❑ **Yes** ❑ **No**
If **Yes**, what is the translator's relationship to the Proposed Insured? _____