John Hancock

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Examiner's Report

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.

SECTION A: Proposed Insured

1. a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

SECTION B: Medical Observations

2. a. Height _____
   Did you measure? ☐ Yes ☐ No
   b. Weight _____
   Did you weigh? ☐ Yes ☐ No
   c. Any weight change in the past 12 months? ☐ Yes ☐ No
   If Yes, amount _____ ☐ Loss ☐ Gain
   Reason _____

3. Blood Pressure Readings

	1.	2.	3.
Systolic			
Diastolic			

4. Pulse _____ ☐ Regular ☐ Irregular
   Type of irregularity _____
   If extra systoles, No. per min. _____

5. Describe general appearance _____

6. Did anyone accompany the Proposed Insured during the examination? ☐ Yes ☐ No
   If Yes, please provide details
   Name of the person who came _____ Relationship to Proposed Insured _____
   Why present _____

7. Did the Proposed Insured understand and answer all the questions asked in connection with this exam? ☐ Yes ☐ No
   If No, please provide details _____

8. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? ☐ Yes ☐ No
   If Yes, please provide details _____

9. Additional observations/comments (if applicable)

SECTION D: Examiner's Certification and Signature

How did you identify the Proposed Insured? ☐ Driver's License (with photo) ☐ Other photo ID _____

Examination location ☐ Examiner's Office ☐ Proposed Insured's home ☐ Proposed Insured's place of business

Indicate requirements completed ☐ Blood ☐ Urine ☐ EKG ☐ TST

Ticket number _____ Date sent to lab MONTH DAY YEAR Date sent to home office MONTH DAY YEAR

Indicate any requirements not completed and reason

I hereby certify that I have personally examined the Proposed Insured and have correctly and fully reported my findings.

SIGNED AT CITY STATE THIS DAY OF YEAR

☐ MD ☐ RN
☐ DO ☐ RPN/LPN

NAME OF EXAMINER

X _____
SIGNATURE OF EXAMINER

Company
☐ APPS ☐ EMSI ☐ Exam One ☐ Portamedic
☐ Superior Mobile Medics ☐ Other _____
City/State Telephone No.

Examination completed on (date and time)
MONTH DAY YEAR
Time