

## Minnesota Life Insurance Company Mature Assessment

Name of Proposed Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Date: \_\_\_\_\_

Print Examiner Name: \_\_\_\_\_

Instruction for Examiner: This supplement is required on older aged applicants and is to be completed in addition to the usual requirements. The Senior Supplement includes:

1. Get Up and Go Test
2. Peak Flow Test
3. Activities of daily living section
4. Clock Draw

### 1. GET UP AND GO TEST: TIMED GET UP AND GO TEST

Time the number of seconds it takes for the applicant to rise from a chair, walk 10 feet and return to the chair and sit back down. Timing should begin when the applicant begins standing up from a chair and ends when sitting back down. \_\_\_\_\_ seconds

#### CHECK ALL THAT APPLY

ARISING	WALKING
<input type="checkbox"/> Able with ease, requires one attempt	<input type="checkbox"/> Walks without aid
<input type="checkbox"/> Unable without help or loses balance, or requires two or more attempts	<input type="checkbox"/> Mild/moderate deviation/difficulty or uses walking aid
	<input type="checkbox"/> Marked deviation or difficulty
TURNING	SITTING
<input type="checkbox"/> Steady, without aid or hesitation	<input type="checkbox"/> Able, in smooth motion without hesitation
<input type="checkbox"/> Mild staggering, but catches self, or uses aid (for example, the wall) for support	<input type="checkbox"/> Unable without help or collapses (drops/plops) into chair
<input type="checkbox"/> Needs support; specify: _____	
<input type="checkbox"/> Stumbles or almost falls	

Observations/Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Minnesota Life Insurance Company Mature Assessment

Name of Proposed Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**2. PEAK FLOW TEST**

The peak flow procedure consists of a total of three peak flow attempts. If, for any reason, the applicant experiences any respiratory difficulties during the procedure, cannot or refuses to complete three attempts, stop testing and record the reason in the Observation/Remarks section.

Ask the applicant to stand. Hand the peak flow meter device to the applicant, explain the procedure and instruct him/her to perform the test. Repeat this procedure two more times for a total of three readings. Record all 3 readings in L/min in the three designated spaces.

**Peak Flow Meter Test Results:**

**1st Attempt:** \_\_\_\_\_ Liters/min    **2nd Attempt:** \_\_\_\_\_ Liters/min    **3rd Attempt:** \_\_\_\_\_ Liters/min

Determine the predicted values from the Normal Predicted Average. Peak Expiratory Flow (L/min) Chart.

**Gender:** ☐ M   ☐ F      **Age:** \_\_\_\_\_ years old      **Height:** \_\_\_\_\_ total inches

**Predicted Value:** \_\_\_\_\_ (Liter/min)

**Observations/Remarks:** \_\_\_\_\_

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**3. ACTIVITIES OF DAILY LIVING**

A) What is the highest level of education you have completed? (Check one)

- |  |   |
|--|---|
| <input type="checkbox"/> Advanced college degree | <input type="checkbox"/> College degree               |
| <input type="checkbox"/> High School             | <input type="checkbox"/> Did not complete high school |

B) Which of these household activities do you perform regularly? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Cleaning         | <input type="checkbox"/> Lawn mowing       |
| <input type="checkbox"/> Laundry          | <input type="checkbox"/> Shopping          |
| <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Handling finances |
| <input type="checkbox"/> Using a computer |  |

C) Do you need help with any of the following? (Check all that apply) .

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Cooking  | <input type="checkbox"/> Taking medication  |
| <input type="checkbox"/> Banking  | <input type="checkbox"/> Laundry            |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Making phone calls |

Minnesota Life Insurance Company Mature Assessment

Name of Proposed Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_

- D) Have you had any falls in the past 3 years? ☐ YES ☐ NO  
If yes, how many falls in the **past year**? \_\_\_\_\_

Give details and dates in the remarks section below. *(If needed, use the addendum page)*

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- E) Do you exercise? ☐ YES ☐ NO  
If yes, what type of exercise and how often? \_\_\_\_\_

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- F) Are you self-employed, a homemaker, or living off your own earnings? ☐ YES ☐ NO  
If yes, how many hours do you work per week? \_\_\_\_\_ hours

- G) Do you participate in any of the following? *(Check all that apply)*

☐ Hobbies ☐ Volunteer Work ☐ Other outside activities

If yes, explain and indicate the number of hours you participate each week. \_\_\_\_\_

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- H) Do you travel? ☐ YES ☐ NO  
If yes, give details including the average number of times each year, date and destination  
Of last trip, and your travel plans for the next 12 months: \_\_\_\_\_

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- I) Do you currently drive? ☐ YES ☐ NO  
If no, when and why did you stop? \_\_\_\_\_

If yes, give the number of miles driven per week and number of accidents in past 2 years.

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Minnesota Life Insurance Company Mature Assessment

Name of Proposed Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_

J) Do you own any pets? ☐ YES ☐ NO

If yes, what pets do you own? \_\_\_\_\_

K) Are there other persons living in your household? ☐ YES ☐ NO

If yes, indicate how many adults \_\_\_\_\_ and how many children \_\_\_\_\_

L) Where do you live now? (*house, apartment, etc.*)

\_\_\_\_\_

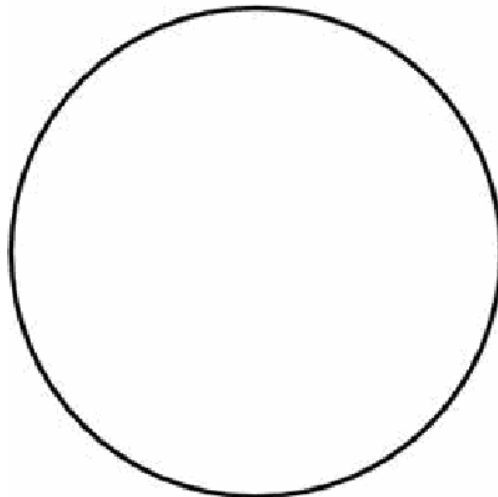
M) If you could not afford to live alone where you do now, who would you prefer to live with?  
(*family member, assisted care facility, etc.*)

\_\_\_\_\_

**4. CLOCK DRAW TEST**

**\*Make sure the applicant understands your instructions, but you do not need to score this test.**

**Examiner Instructions to the applicant: (Draw Clock Test)** "The circle represents a clock face. Please put the numbers around the clock in the correct positions, then set the clock at 10 minutes past 11."



Minnesota Life Insurance Company Mature Assessment

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**Examiner Observations**

You, as the examiner, play a vital role in giving your general observations, so that a clear picture may be obtained of this person's physical and cognitive abilities. Due to the sensitive nature of these questions, please complete this page *after* you have left the exam appointment. Any observations you make will be taken seriously. Please be honest in the following observations.

1. What is the person's general affect? (cheerful, depressed, tired, etc)

\_\_\_\_\_

2. Does he/she have difficulty walking, sitting, rising? ☐ YES ☐ NO

3. Is there difficulty with understanding directions? ☐ YES ☐ NO

4. If a friend or relative accompanies this person, does the applicant seem to rely on that person for physical help or in following directions? ☐ YES ☐ NO

5. How is the applicant dressed? (*neatly, sloppily, etc.*) ☐ YES ☐ NO

\_\_\_\_\_

6. Are there other observations you would like to make?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Examiner Signature**

\_\_\_\_\_  
**Date**