**PACIFIC LIFE INSURANCE COMPANY**
Life Insurance Division
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com

# APPLICATION FOR INDIVIDUAL LIFE INSURANCE – MEDICAL EXAMINER'S REPORT

For Proposed Insured age 16 and older

| Proposed Insured's Name: First | MI | Last | Date of Birth (mm/dd/yyyy) | Policy Number, if applicable |
|---|---|---|---|---|
| | | | | |

**Physician Information** (Indicate the most recent physician/medical facility seen within the last 5 years.)

*Primary Care Physician Information*

| 1A. Physician/Medical Facility Name | | | B. Telephone # (include area code) |
|---|---|---|---|
| C. Address: Street | City | State | Zip Code |

| 2A. Date of Last Visit | B. Reason for Visit |
|---|---|

*Specialist Information*

| 3A. Physician Name | | B. Type of Specialty | C. Telephone # (include area code) |
|---|---|---|---|
| D. Address: Street | City | State | Zip Code |

| 4A. Date of Last Visit | B. Reason for Visit |
|---|---|

**Tobacco Use Information** (Complete if Proposed Insured is age 18 and above. The age of a juvenile insured varies by product. The responses to the following questions will not be considered in underwriting for products where the Insured is a juvenile Insured as defined in the contract.)

5. Within the last 5 years, have you used or smoked tobacco and/or any other product containing nicotine in any quantity? ☐ Yes ☐ No
(If Yes, check all that apply and indicate date when product was last used below)

| Type of Product | Date last used (mm/yyyy) | Type of Product | Date last used (mm/yyyy) |
|---|---|---|---|
| ☐ Cigarettes | | ☐ Chewing Tobacco | |
| ☐ E-cigarette | | ☐ Nicotine Patch | |
| ☐ Cigars | | ☐ Nicotine Gum | |
| ☐ Pipe | | ☐ Other_____ | |

**Physical Measurements**

| | Yes | No |
|---|---|---|
| 6A. Height:_____ Weight:_____ | | |
| B. Has there been a weight gain of 10 pounds or more in the past 12 months? (If yes, how many pounds?) _____ | ☐ | ☐ |
| C. Has there been a weight loss of 10 pounds or more in the past 12 months? (If yes, how many pounds?) _____ | ☐ | ☐ |
| D. Was weight loss due to diet or exercise? | ☐ | ☐ |

**Family Health History**

| | Yes | No |
|---|---|---|
| 7. Have either of your parents, brothers or sisters ever been diagnosed by a member of the medical profession to have diabetes, cancer, high blood pressure, heart disease, or stroke? (If yes, state condition, give relationship and age at onset.) | ☐ | ☐ |

8. Complete chart for any deceased family members listed below:

| | Age At Death | Cause of Death |
|---|---|---|
| A. Father | | |
| B. Mother | | |
| C. Sibling | | |
| D. Sibling | | |

**Health History for Proposed Insured** (Have you been diagnosed by a medical professional for any of the following? For Yes answers provide diagnosis, treatment, test results, medications, dates of any hospitalization and/or recommendations for surgery (within the last 5 years) and the name/address of the physicians. If more space is needed, use the "Application for Individual Life Insurance – Additional Information" form.)

| | Yes | No |
|---|---|---|
| 9. Except for HIV, have you taken medication, been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following: | | |
| A. Chest pain, angina, congestive heart failure, heart attack, heart disease, heart murmur, irregular heart rhythm, coronary artery disease, atrial fibrillation, any other heart or blood vessel disorder or disease? | ☐ | ☐ |
| B. Peripheral vascular disease, high blood pressure or high cholesterol? | ☐ | ☐ |
| C. Jaundice, cirrhosis, hepatitis, ulcers, colitis, diverticulitis, or any other liver, stomach, gallbladder or intestinal disorder or disease? | ☐ | ☐ |
| D. Kidney failure, kidney or bladder stones, or any other kidney or bladder disorder or disease? | ☐ | ☐ |
| E. Pancreatitis or any other pancreas disorder or disease? | ☐ | ☐ |
| F. Diabetes, glucose intolerance, high blood sugar, thyroid, other endocrine or glandular disorder or disease? | ☐ | ☐ |
| G. Asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, tuberculosis, or any other respiratory system disorder or disease? | ☐ | ☐ |
| H. Anemia, bleeding or clotting disorder or disease? | ☐ | ☐ |
| I. Blood, blood cells or bone marrow disorder or disease, recurrent infections, or any other immune system disorder or disease? | ☐ | ☐ |
| J. Cancer, leukemia, lymphoma, lymph node disorder or disease, malignant melanoma, any tumors, cyst or polyps? | ☐ | ☐ |
| K. Stroke, transient ischemic attack (TIA), paralysis, epilepsy, seizures, convulsions, headaches or other neurological disorder or disease? | ☐ | ☐ |
| L. Alzheimer's disease, dementia, cognitive impairment, or any other brain or nervous system disorder or disease? | ☐ | ☐ |
| M. Multiple sclerosis, Parkinson's disease, Huntington's disease, Lou Gehrig's disease (ALS), muscular dystrophy or any other muscular or skeletal system disorder or disease? | ☐ | ☐ |
| N. Lupus, scleroderma or any other connective tissue disorder or disease? | ☐ | ☐ |
| O. Gout, osteoporosis, sciatica, cerebral palsy, myasthenia gravis, sjogren's, osteomyelitis, arthritis, rheumatoid arthritis, or any other muscle, bone, spine, back, neck, or joint disorder or disease? | ☐ | ☐ |
| P. Chronic fatigue, fibromyalgia, chronic pain, polymyalgia rheumatica, neuropathy or nerve disorder or disease? | ☐ | ☐ |
| Q. Breast, prostate, or any reproductive organ disorder or disease? | ☐ | ☐ |
| R. Any eye, ear, nose, throat or skin disorder or disease? | ☐ | ☐ |
| S. Any amputations? | ☐ | ☐ |
| T. Sexually transmitted diseases? | ☐ | ☐ |
| 10. Within the last 5 years have you used or have you been given medical advice by a member of the medical profession to use dialysis machine, ostomy, pacemaker? (If yes, give dates, how long or often and reason.) | ☐ | ☐ |
| 11. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? | ☐ | ☐ |
| 12. Have you ever used or tested positive for: tranquilizers, sedatives, narcotics, barbiturates, amphetamines, heroin, cocaine, hallucinogens, marijuana, any other habit forming drug or any controlled substance? (If yes, what drugs have you used, what quantity and date last used.) | ☐ | ☐ |
| 13. Have you been prescribed medical marijuana by a member of the medical profession? (If yes, provide the name of the prescribing physician and the reason marijuana is being prescribed.) | ☐ | ☐ |
| 14. Within the last 5 years, have you been diagnosed, treated, or been given medical advice by a member of the medical profession and/or taken medication for: anxiety, schizophrenia, bi-polar disorder, depression, other psychiatric disorder and any other mental health or nervous disorder? | ☐ | ☐ |
| 15. Do you drink alcoholic beverages? (If yes, provide type, frequency and amount.) | ☐ | ☐ |
| 16. Within the last 5 years, have you had medical treatment or counseling for the use of alcohol or drugs, or participated in a support group because of alcohol or drug use? | ☐ | ☐ |
| 17. Other than any you previously mentioned and except for HIV, within the last 5 years: | | |
| A. have you been advised by a member of the medical profession that you have had an abnormal medical test, including a blood test, urine test, EKG, echocardiogram, or other test? | ☐ | ☐ |
| B. have you had any X-Ray, diagnostic medical tests/procedures? | ☐ | ☐ |
| C. have you had any check-up, consultation, illness, confinement to medical facility, or surgery? | ☐ | ☐ |
| D. have you been advised by a member of the medical profession to have a consultation, diagnostic test, surgery, or confinement to medical facility that has not yet been completed? | ☐ | ☐ |
| 18. Do you take any other medications regularly, including over-the-counter medications, not previously mentioned? (If yes give the name of the medication, dose and frequency.) | ☐ | ☐ |
| 19. Within the last 5 years, have you received or applied for any disability benefits, Worker's Compensation, Social Security Disability Insurance, chronic illness, long-term care, or accidental medical benefits? (If yes, include dates and types of benefits.) | ☐ | ☐ |

**RETURN REMARKS PAGE EVEN IF BLANK**

**Remarks** (Use remarks sections for additional detail or clarifications. If more space is needed use the “Application for Individual Life Insurance - Additional Information” form.)

**Additional Questions for Proposed Insured Age 61 or Older** (Have you been diagnosed by a medical professional for any of the following? For Yes answers provide diagnosis, treatment, medications and the name/address of the physicians. If more space is needed, use the "Application for Individual Life Insurance – Additional Information" form.)

| | Yes | No |
|---|---|---|
| 20. Within the last 5 years, have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: | | |
| A. Vertigo, dizziness, fainting/syncope, loss of balance or falls? | ☐ | ☐ |
| B. Amnesia, confusion, memory loss, hydrocephalus, post-polio syndrome? | ☐ | ☐ |
| 21. Within the last 5 years, have you been given medical advice by a member of the medical profession to have chiropractic care, occupational therapy, respiratory therapy, speech therapy, or physical therapy? (If yes, provide dates of care or therapy and outcome.) | ☐ | ☐ |
| 22. Within the last 5 years, have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision with performing the following activities: (If yes, who helps, how often, for what specific activities and why?) | ☐ | ☐ |
| A. housekeeping, meal preparation, laundry, telephone use, managing your finances, managing and/or taking your medications, shopping, or transportation? | ☐ | ☐ |
| B. bathing, dressing, eating, toileting, controlling your bowel or bladder, walking, moving from a seated or laying down position? | ☐ | ☐ |
| 23. Is someone acting for you in a legal capacity through a Power of Attorney? (If yes, provide date, reason and relationship.) | ☐ | ☐ |
| 24. Within the last 5 years, did you or do you use a brace, cane (of any kind), walker, wheelchair, motorized scooter, hospital bed, stair/chair lift, catheter or personal oxygen system? (If yes, specify device and provide the reason and dates.) | ☐ | ☐ |
| 25. Within the last 5 years, have you been given medical advice by a member of the medical profession to attend adult day care, receive home health care, be admitted to an assisted living facility, a custodial facility, nursing home/facility, psychiatric treatment center, hospital or any other medical facility? (If yes, provide reason, how often you attend, dates, name and address of facility and physician who recommended admissions.) | ☐ | ☐ |

**Remarks** (Use remarks sections for additional detail or clarifications. If more space is needed use the "Application for Individual Life Insurance - Additional Information" form.)

## Signatures

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The answers provided in this application and any additional details provided are true and complete to the best of my knowledge and belief. I understand and agree that this application will be attached to and made part of the policy.

If proposed insured is under age 18, a signature of the parent/guardian is required in place of the minor's signature.

SIGNED IN:

| City | State |
|---|---|
| | |

DATED ON:

| Date (mm/dd/yyyy) |
|---|
| |

X

Proposed Insured's Signature (or parent/guardian if a minor)

## Medical Examiner's Certification

I certify that I have truly and accurately recorded the information supplied in this application.

X

Examiner's Signature, include title/designation

# This Page Is Not A Part Of The Application For Insurance

**Measurements**

26. Did you measure the proposed insured's height? ☐ Yes _____ft. _____in. ☐ No

27. Did you weigh the proposed insured? ☐ Yes _____lbs. ☐ No

**Blood Pressure**
(Record Systolic/Diastolic sitting and the Diastolic at cession of sound. If 140/90 or over must give at least two additional readings.)

28. Initial Reading: _____/_____

29. Additional Reading 1: _____/_____

30. Additional Reading 2: _____/_____

**Pulse**

| | At Rest | After Exercise | Minutes Later |
|---|---|---|---|
| 31. Rate: | | | |
| 32. Irregularities Per Minute: | | | |

**Mobility Assessment for Proposed Insured Age 71 or Older**

EXAMINER INSTRUCTIONS: (A STRAIGHT BACK ARMLESS CHAIR IS PREFERRED)

- Ask the proposed insured to rise from his/her chair and walk 10 feet, turn around, walk back to the chair, and sit back down.
- Time how long it takes the proposed insured to perform the above task and record the elapsed time (in seconds) below.
- Observe the proposed insured's mobility and then record the answers below, including details of any difficulties.

33. Rising from chair:
- ☐ Rises easily with no assistance
- ☐ Requires more than one attempt
- ☐ Has trouble with balance, needs assistance, or has significant difficulty

34. Turning:
- ☐ Smoothly with no hesitation
- ☐ Needs mild assistance or has mild difficulty
- ☐ Stumbles or needs support

35. Walking:
- ☐ Unassisted at a normal pace
- ☐ With assistance or mild difficulty
- ☐ Stumbles, extremely slow pace, needs substantial assistance

36. Sitting down in chair:
- ☐ Smoothly with no hesitation
- ☐ Drops suddenly into chair or if chair has armrests used them for support
- ☐ Needs assistance

Comments

Elapsed Time: _____

**Lab Kit** (Complete the required tests and send to ExamOne. Mark below which are included in the kit.)

37. ☐ Paramed ☐ Blood Profile ☐ HOS
☐ Electrocardiogram ☐ Other:_____

**Exam Information**

38. Examined at: ☐ My office ☐ Other: _____

39. Date of Exam (mm/dd/yyyy): _____ 40. Time of Exam: _____ ☐ AM ☐ PM

41. Name of Producer Requesting Exam: _____

**Medical Examiner's Information** (Social Security or Tax Identification Number is required for reporting fee payments.)

| Name: First | MI | Last | SSN/TIN |
|---|---|---|---|
| Address: Street | | City | State Zip Code |

SIGNED AND DATED ON: Date (mm/dd/yyyy)

I certify that I have truly and accurately recorded the information supplied above.

SIGN HERE

X _____

Examiner's Signature, include title/designation