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To help us assess additional risk factors sometimes associated with the elderly, please complete the mature age supplement for Proposed Life Insureds ages 71 and older in addition to the regular medical examination. The mature age supplement includes tests for memory, mobility and questions on activities of daily living.

Complete the medical exam, the Examiners report and then move onto the Mature Age supplement.

## **Orientation**

### Section A

- Please record the Proposed Life Insured's responses.

## **Delayed Word Recall (Important: Please read carefully)**

### Section B (Part I)

Before beginning the interview, separate the ten words on the last page by cutting along the dashed line, to be used flash-card style.

- Explain to the applicant that this is a memory test
- Show the first word on the card and ask him or her to say the word out loud and use it in a sentence. Follow the same procedure for the remaining 9 words.
- Repeat the process a second time. They do not have to use the same sentences again. They can make up a new sentence.
- Check your watch and record the time the last sentence was completed.
- **This completes Part I. Please keep your eye on your watch. You will be completing Part II in 5 minutes (no longer than 10 minutes).**
- You may now continue on to the activities of daily living questions.

## **Activities of Daily Living**

### Section C

- Please ask the applicant the questions listed and record any additional information in the space provided.

## **Delayed Word Recall**

### Section D (Part II)

- If it has been 5 minutes since you completed Part I of the Delayed Word Recall, you may now begin Part II.
- Ask the applicant to recall as many words as they can from Part 1. Check off the words they recall and indicate how many out of the ten words were recalled.

## **Mobility – Get Up and Go Test**

### Section E

- You will need a stop watch for this task. Advise the applicant this is a walking test.
- Record how long it takes (in seconds) for the applicant to get up from a seated position, walk ten feet, return and sit down again.
- Record if it took the applicant 20 seconds or more to complete this task. Please comment on any abnormalities of the items listed.

## **Examiner Observations**

### Section F

- Please answer the questions listed and provide any additional comments.



Service Office:  
Life New Business  
197 Clarendon Street  
Boston MA 02116-5010

**Medical Exam**  
**John Hancock Life Insurance Company (U.S.A.)**  
(hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured.  
Notice of Disclosure of Information form NB5006 must be used with this Medical Exam if it is being submitted on its own without the main application.  
Print and use black ink. Any changes must be initiated by the Proposed Life Insured.

**PROPOSED LIFE INSURED**

1. a) Name \_\_\_\_\_  
First Middle Last
- b) Date of Birth \_\_\_\_\_  
month day year
- c) Social Security/Tax ID Number \_\_\_\_\_
- d) Sex  Male  Female

**SMOKING STATUS**

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?  
 Yes  No If 'Yes', provide details below.

Product:	Frequency:	Current	Past	Date Last Used		
				month	day	year
Cigarettes _____	pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**FAMILY QUESTIONS**

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60?  Yes  No
4. Please provide the following details.

L I V I N G	Family History	Age	Give Details of Present State of Health
	Father		
	Mother		
	Brothers & Sisters		

D E C E A S E D	Family History	Age	Cause of Death
	Father		
	Mother		
	Brothers & Sisters		

5. a) Name and Address of Personal or Attending Physician

\_\_\_\_\_  
First Middle Last

\_\_\_\_\_  
Street No. & Name Suite No. City State Zip code

b) Telephone No. \_\_\_\_\_

c) Date last consulted \_\_\_\_\_ Reason for consultation \_\_\_\_\_ Diagnosis/Result of visit \_\_\_\_\_  
month day year

d) List any medications (prescription or nonprescription) you are taking currently \_\_\_\_\_

## HEALTH QUESTIONS

Please complete  
Details for 'Yes'  
answers on  
page 3.

6. **Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have:**
- a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries?  Yes  No
  - b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease?  Yes  No
  - c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?  Yes  No
  - d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis?  Yes  No
  - e) Any nervous, mental or emotional disorder, or received counseling for anxiety, depression, stress, or any other emotional condition?  Yes  No
  - f) Alzheimer's disease, dementia, memory loss or organic brain syndrome?  Yes  No
  - g) Multiple sclerosis (MS), muscular dystrophy, ALS (Lou Gehrig's disease), Parkinson's disease or tremors?  Yes  No
  - h) Injuries due to falls or imbalance?  Yes  No
  - i) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, fractures, or any other bone, joint or muscle disorder?  Yes  No
  - j) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder?  Yes  No
  - k) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines?  Yes  No
  - l) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts?  Yes  No
  - m) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders?  Yes  No
  - n) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine?  Yes  No
  - o) Cancer, leukemia, lymphoma, malignant melanoma or tumors of any kind, malignant or benign?  Yes  No
  - p) Any other health impairment or medically treated condition?  Yes  No
7. **Within the last 10 years have you had:**
- a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident?  Yes  No
  - b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), whether conducted on an in-patient or out-patient basis?  Yes  No
8. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?  Yes  No
9. Do you:
- a) have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed?  Yes  No
  - b) consume alcoholic beverages?  Never  Currently  In the past
- Complete if **Currently** was selected in 9 b)

Complete if **In the past** was selected in 9 b)

Type of beverage	Frequency	Quantity
Date Stopped _____ month _____ year		
Reason Stopped _____		
10. **Within the last 10 years have you:**
- a) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counseling or participated in a support group?  Yes  No
  - b) used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens?  Yes  No
  - c) used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions?  Yes  No



Print and use black ink.

**PROPOSED LIFE INSURED**

1. a) Name \_\_\_\_\_ b) Date of Birth \_\_\_\_\_  
First Middle Last month day year

**SECTION 1**

**Complete for all paramedicals and medical examinations.**

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 Life Insured during the examination?  Yes  No  
 If 'Yes', please provide details  
 Name of the person who came \_\_\_\_\_ Relationship to Proposed Life Insured \_\_\_\_\_  
 Why present \_\_\_\_\_
7. Did the Proposed Life 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 \_\_\_\_\_

**SECTION 2**

**Complete only for medical examinations.**

9. On examination is/are there any:  
 a) Extra or abnormal heart sounds?  Yes  No  
 b) Murmurs?  Yes  No  
 c) Cardiomegaly or cardiac enlargement?  Yes  No  
 d) Inadequate circulation anywhere?  Yes  No  
 If 'Yes', provide details below. (e.g. shortness of breath, edema, stasis dermatitis, PVD)

**Please complete the following heart chart if there are any YES answers to question 9, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or if there is a history of hypertension or heart disease.**

**Murmur** If more than one, describe in Details below.

None  Systolic  Diastolic | Grade I II III IV V VI |  Loud  Harsh  Rough  Soft  Blowing

- Signs of Failure**
- Shortness of breath?  Yes  No  
 Cyanosis?  Yes  No  
 Engorgement of neck veins?  Yes  No  
 Swelling of ankles?  Yes  No  
 Rales at lung bases?  Yes  No

Location  
 Area of Murmur by \_\_\_\_\_ xxxxx  
 Transmission by \_\_\_\_\_





Print and use black ink.

**PROPOSED LIFE INSURED**

1. a) Name \_\_\_\_\_ b) Date of Birth \_\_\_\_\_  
First Middle Last month day year

Please introduce this part of the exam to the Proposed Life Insured by telling him or her that this part of the examination is an assessment of his or her mobility, daily living activities and memory.

**A. ORIENTATION**

Please record the Proposed Life Insured's answer.

What is the month \_\_\_\_\_ year \_\_\_\_\_ day of the week \_\_\_\_\_ day of month \_\_\_\_\_

**B. DELAYED WORD RECALL - PART I**



1. Advise the Proposed Life Insured this is a memory test. You will be showing him or her 10 words and he or she will be asked to recall these words at a later time. Use the flash word cards attached at the end of this questionnaire. Show the Proposed Life Insured each word. Ask him or her to read each word aloud and use it in a sentence. Do not record the sentences.
2. Repeat the process a second time requiring the Proposed Life Insured to again use each word in a sentence. He or she may either make up a new sentence or use the same sentence used before.
3. Put the word flash cards out of sight. Record the time of completion.
4. This will complete Part I. You will complete Part II of the Delayed Word Recall in 5 minutes.

Time of completion \_\_\_\_\_ a.m/p.m.

**C. ACTIVITIES OF DAILY LIVING**

Ask the Proposed Life Insured the following questions and record the answers.

- a) Do you drive?  Yes  No  
 If 'Yes', to where and for what distance do you drive? \_\_\_\_\_  
 If 'No', when and why did you stop driving? \_\_\_\_\_
- b) Have you had any car accidents in the last 2 years?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- c) Do you live alone?  Yes  No  
 If 'No', who do you live with? \_\_\_\_\_
- d) Have you had any falls in the last 2 years?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- e) Have you had any visits to the hospital emergency room in the past 12 months?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- f) Do you belong to any social groups, social clubs or do any volunteer work?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- g) How many times a week do you engage in social activities outside of your home?  
 Record details \_\_\_\_\_
- h) Do you do any travel?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- i) Who does the housework or yard work at your home? \_\_\_\_\_
- j) Who shops for food, clothing and personal items for you? \_\_\_\_\_
- k) Who pays the bills, manages finances and balances the checkbook? \_\_\_\_\_
- l) Do you need any assistance with your laundry or taking your medication?  Yes  No  
 If 'Yes', record details \_\_\_\_\_
- m) Do you require any assistance with dressing, bathing, eating, transferring, toileting?  Yes  No  
 If 'Yes', record details \_\_\_\_\_

## D. DELAYED WORD RECALL – PART II

If it has been 5 minutes since you completed Part I of the delayed word recall, please now complete Part II and then resume the remainder of the exam.



Ask the Proposed Life Insured to recall as many of the words he or she can from Part I. You will check off the words below and then record the total number of words recalled correctly.

STATE : Earlier I asked you to repeat 10 words and use those words in a sentence. At this time I would like you to recall as many of those words as you can remember.

List  Tree  Pencil  Train  Finger  Puppy  Flower  Door  Towel  Hair  Bed

Total number recalled \_\_\_\_\_/10

## E. MOBILITY



This task will need to be timed with a stopwatch. Record the time it took to complete the entire task in seconds. Ask the Proposed Life Insured to get up from a seated position, walk 10 feet, return and sit down again.

Time: \_\_\_\_\_ seconds (for entire process)

If the time is greater than or equal to 20 seconds, then please comment on any abnormalities of the following:

Ability to rise from the chair \_\_\_\_\_

Steady or Unsteady \_\_\_\_\_

Ability to make turns \_\_\_\_\_

Hesitancy \_\_\_\_\_

Awkward or abnormal Gait \_\_\_\_\_

Posture \_\_\_\_\_

## F. OBSERVATIONS

a) Does the Proposed Life Insured require any assistance from another person or the use of any adaptive devices (ie cane, walker etc)?  Yes  No

If 'Yes', record details \_\_\_\_\_

b) Does the Proposed Life Insured have any evidence of a cognitive disorder? (dementia, memory loss, confusion, behavioral change, lack of comprehension)  Yes  No

If 'Yes', record details \_\_\_\_\_

c) Describe the Proposed Life Insured's personal grooming. (well dressed, clean, neat, or unkempt, fragile, poorly groomed)

d) Living environment - If the interview was conducted in the Proposed Life Insured's home, please describe living conditions or any safety issues. (clean, stairs, one level home, untidy, disrepair etc)

e) Describe any other general observations or comments you, the examiner, would like to make about the Proposed Life Insured.

## SIGNATURE

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

Signed at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_ Year \_\_\_\_\_

Name of Examiner \_\_\_\_\_

MD  RN  
 DO  RPN/LPN

Signature of Examiner

**X**

Company

APPS  EMSI  Exam One  Portamedic  
 Superior Mobile Medics  Other \_\_\_\_\_

Examination completed on (date and time) \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ Time

City, State \_\_\_\_\_

Telephone No. \_\_\_\_\_

**FLASH WORD CARDS**

Use these 10 words flash card style for the Delayed Word Recall



**TREE**

**PENCIL**

**TRAIN**

**FINGER**

**PUPPY**

**FLOWER**

**DOOR**

**TOWEL**

**HAIR**

**BED**

