

PACIFIC LIFE INSURANCE COMPANY

MED

Life Insurance Operations Center
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 www.PacificLife.com



PACIFIC LIFE

APPLICATION, PART II – MEDICAL

SECTION A COMPLETE ON PROPOSED INSURED (AGE 16 OR OVER)

1. Name: First _____ MI _____ Last _____	2a. Date of Birth (MO/DAY/YR) _____	2b. Height FT. _____ IN. _____	2c. Weight LBS. _____
---------------------------------------------------------------	--------------------------------------------	------------------------------------------	---------------------------------

3. a. Name and address of physician or practitioner last seen: _____
(IF NONE, SO STATE)

b. Date: _____ **c. Reason consulted:** _____
MO. YR

- d. Did any symptoms prompt consultation?** **Yes** **No**
- e. Was any treatment given or medication prescribed?** **Yes** **No**

(IF "D" OR "E" ANSWERED "YES" GIVE DETAILS)

4. To the best of your knowledge and belief, during the past 10 years, have you had, or been told that you had, or been treated by a member of the medical profession for:
(CIRCLE APPLICABLE ITEMS AND GIVE DETAILS)

- a. Disorder of the eyes, ears, nose, or throat?** **Yes** **No**
- b. Dizziness, fainting, convulsions, headaches, speech defect, paralysis or stroke, or mental or nervous disorder?** **Yes** **No**
- c. Hoarseness or cough, blood spitting, asthma, pneumonia, emphysema, tuberculosis, or other respiratory system disorder?** **Yes** **No**
- d. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?** **Yes** **No**
- e. Jaundice, intestinal bleeding, ulcer, colitis, diverticulitis, hepatitis, or other disorder of the liver, gallbladder, stomach, or intestines?** **Yes** **No**
- f. Sugar, albumin, or blood in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, breasts or reproductive organs?** **Yes** **No**
- g. Diabetes, thyroid, or other endocrine disorders?** **Yes** **No**
- h. Neuritis, sciatica, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?** **Yes** **No**
- i. Cancer, cyst, tumor or disorder of skin, blood, or lymph glands?** **Yes** **No**
- j. Any disorder(s) of the immune system, including AIDS (Acquired Immune Deficiency Syndrome) and ARC (AIDS-Related Complex)?** **Yes** **No**

5. a. Have you within the past 5 years been a patient in a hospital, clinic, sanitarium, or other medical facility? **Yes** **No**
b. Are you now under regular medical observation or taking treatment? **Yes** **No**

6. a. Except as prescribed by a physician, have you used heroin, morphine, or other narcotic drugs in the last 10 years? **Yes** **No**
b. Except as prescribed by a physician, have you used cocaine, LSD, marijuana, or other hallucinogenic agents, or barbiturates, sedatives, tranquilizers, or any amphetamines in the last 5 years? **Yes** **No**
c. In the last 5 years have you received treatment for or joined an organization because of alcoholism or drug addiction? **Yes** **No**

7. Other than as stated in answers above, have you within the past 5 years:
a. Had a checkup, consultation, illness, injury, or operation? **Yes** **No**
b. Had an electrocardiogram, blood test, other test or X-ray? **Yes** **No**
c. Been advised to have any diagnostic test, hospitalization, or surgery that was not completed? **Yes** **No**
8. Have you had any change in weight in the past year? **Yes** **No**
9. Have either of your parents, brothers, or sisters had diabetes, cancer, high blood pressure, heart disease, or mental illness? **Yes** **No**
(IF "YES" STATE CONDITION, GIVE RELATIONSHIP AND AGE AT ONSET)

10. Parents' Record (COMPLETE BELOW):

	IF LIVING		IF DECEASED	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				

Details of "Yes" answers. (Identify question; and include diagnoses, dates, duration, and names and addresses of all attending physicians and medical facilities.) Use an additional sheet if necessary.

- 11. a. Do you currently smoke cigarettes?** **Yes** **No**
- b. If "Yes" how many a day?** _____
- c. Did you ever smoke cigarettes?** **Yes** **No**
- d. If "Yes" on 11(c), give date last cigarette smoked:** _____
MO. YR.
- e. Do you use tobacco in any other form?** **Yes** **No**
(IF "YES" SPECIFY TYPE IN "REMARKS")
- f. Have you used tobacco in any other form within the last 24 mos.?** ... **Yes** **No**
(IF "YES" SPECIFY TYPE IN "REMARKS")

The above statements are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be a part of the application. Any Person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated at _____ CITY _____ STATE _____ on _____ MO. DAY YR. **X** SIGNATURE OF PROPOSED INSURED

WITNESS _____



MEDICAL EXAMINER'S REPORT

12.	Height	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen Relaxed At Umbilicus
	Ft. In.	Lbs.	In.	In.	In.

Did you weigh? Yes No Did you measure? Yes No
 Weight change in past year? _____ lbs. Gain Loss-Cause?
 Is appearance unhealthy or older than stated age? Yes No

13. BLOOD PRESSURE
(RECORD SYST./DIAST. SITTING, THE DIASTOLIC AT CESSATION OF SOUND)
 Initial reading: _____ Syst./Diast.
(IF 140/90 OR OVER, MUST GIVE AT LEAST TWO ADDITIONAL READINGS)

14. PULSE	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities Per Min.			

15. HEART
 (a) Is there any cardiovascular disorder? Yes No
 (b) Is heart enlarged? Yes No (If yes, describe)
 (c) Is murmur present? Yes No (If yes, complete 15d)

- (d) Murmur is: Constant Inconstant
- | | | | |
|--------------------------------------|--------------------------------------|---------------------------------|-----------------------------------------|
| <input type="checkbox"/> Transmitted | <input type="checkbox"/> Systolic | <input type="checkbox"/> Apical | <input type="checkbox"/> Soft (Gr. 1-2) |
| <input type="checkbox"/> Localized | <input type="checkbox"/> Presystolic | <input type="checkbox"/> Basal | <input type="checkbox"/> Mod. (Gr. 3-4) |
| | <input type="checkbox"/> Diastolic | <input type="checkbox"/> Other | <input type="checkbox"/> Loud (Gr. 5-6) |
- After exercise Unchanged Increased
 Decreased Absent

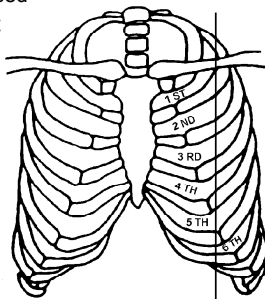
Show location of:

Apex by

Area of murmur by

Point of greatest intensity by

Transmission by



(e) Diagnostic Impression:

16. Is there any abnormality of the following:
(CIRCLE APPLICABLE ITEMS AND GIVE DETAILS)

(a) Eyes, ears, nose, mouth, pharynx	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<small>(IF VISION OR HEARING MARKEDLY IMPAIRED, INDICATE DEGREE AND CORRECTION)</small>		
(b) Skin (incl. scars); lymph nodes; blood vessels	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<small>(INCL. VARICOSE VEINS)</small>		
(c) Nervous system (INCLUDE REFLEXES, GAIT, PARALYSIS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d) Respiratory system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(e) Abdomen (INCLUDING SCARS OR HERNIAS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(f) Genitourinary system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(g) Endocrine system (INCLUDE THYROID AND BREASTS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(h) Musculoskeletal system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<small>(INCLUDE SPINE, JOINTS, AMPUTATIONS, DEFORMITIES)</small>		

17. Have you any pertinent information not brought out above? . . . Yes No

MEDICAL EXAMINER:
X
 SIGNATURE OF MEDICAL EXAMINER
 WHEN PAYING FEES WE ARE REQUIRED TO SHOW AND REPORT SOCIAL SECURITY OR EMPLOYER I.D. NUMBER. PLEASE GIVE US THIS INFORMATION BELOW.
 Include All Hypens → _____
 Examined at
 My Office Other: _____
 Date and Hour of Examination _____ A.M. _____ P.M.

18. URINALYSIS
 (Dip Stick): Protein _____ Sugar _____
 Send specimen to LabOne when:
 (a) There are findings or history of urinary abnormalities or elevated blood pressure; or
 (b) Agent advises amount of insurance requires it.

19. The following are being forwarded:
 Specimen to LabOne*
 Blood Profile to LabOne*
 Electrocardiogram to Pacific Life*
 Other _____
(*REQUESTOR WILL ORDER WHEN NECESSARY)

Examiner's remarks and description of positive findings:

EXAMINER'S NAME AND OFFICE ADDRESS (PLEASE PRINT)
 Name _____
 Street _____
 City _____
 State _____
 Name of Agent Requesting Examination _____
 Mail To: Pacific Life Insurance Company
 New Business Services – Medical Fees Desk
 P.O. Box 2030
 Omaha, NE 68103-2030