

PACIFIC LIFE INSURANCE COMPANY

Life Insurance Operations Center
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 www.PacificLife.com



PACIFIC LIFE

MED PLUS

For Proposed Insured age 75 & above

Proposed Insured's Name: First	MI	Last	Date of Birth (mm/dd/yyyy)
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OBJECT IDENTIFICATION	1. Point to three objects and ask the Proposed Insured to tell you what they are: Record the 3 objects that were pointed to: a. _____ b. _____ c. _____
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ACTIVITY QUESTIONS		Yes	No
1.	Do you exercise? If yes , provide details including exercise capacity and frequency in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you work outside the home, do any volunteer work, or travel? If yes , provide details in Remarks section	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you drive? If no , provide details of when and why stopped in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any gait or mobility problems? If yes , provide details in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you A. use any assistive device (cane, walker, etc.)? B. have a history of falls? If yes , provide details in Remarks section.	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
6.	Have you been diagnosed with any cognitive disorder (dementia, memory loss, confusion, lack of comprehension, behavioral change)? If yes , provide details in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>

Complete questions 7-9 only if the Proposed Insured does not work, volunteer or participate in an exercise program outside the home, or if 4-6 is answered Yes.

ASSISTANCE/MOBILITY QUESTIONS			
7.	Do you need assistance with any of the following activities? (If yes , select which activities require assistance and provide details in the Remarks section) <input type="checkbox"/> Bathing; <input type="checkbox"/> Dressing; <input type="checkbox"/> Eating; <input type="checkbox"/> Transferring; <input type="checkbox"/> Toileting	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you need assistance with any activities of daily living? (If yes , select which activities require assistance and provide details in the Remarks section) <input type="checkbox"/> Cooking; <input type="checkbox"/> House Cleaning; <input type="checkbox"/> Laundry; <input type="checkbox"/> Shopping; <input type="checkbox"/> Meal Preparation; <input type="checkbox"/> Handling Finances; <input type="checkbox"/> Using the telephone; <input type="checkbox"/> Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>
9.	Record how long it takes for the Proposed Insured to complete the following task. Get up from seated position, walk 10 feet, return and sit again. Time: _____ seconds (for entire process)		

REMARKS – IDENTIFY QUESTION AND GIVE DETAILS



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Proposed Insured's Name: First _____ MI _____ Last _____	Date of Birth (mm/dd/yyyy) _____
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COGNITIVE QUESTIONS

1. Ask the Proposed Insured the following:
a. Month _____ b. Year _____ c. Day of the week _____
d. Day of the Month _____ e. Season _____
2. Ask the Proposed Insured to recall the objects that were previously identified from the Object Identification section.
Record the 3 objects recalled:
a. _____ b. _____ c. _____
3. Have the Proposed Insured draw a clock reading 11:10 in the space below after providing the clock drawing instructions on page 3.

Proposed Insured's Signature: _____

EXAM / EXAMINER'S INFORMATION

EXAM INFORMATION

1. Examined at:
 My office Other: _____
2. Date of Exam (mm/dd/yyyy): _____
3. Time of Exam: _____ AM PM
4. Name of Producer Requesting Exam: _____

MEDICAL EXAMINER'S INFORMATION

Name: First _____ MI _____ Last _____	Soc. Sec. # / TIN _____
Address: Street _____ City _____	State _____ Zip Code _____



X _____
Examiner's Signature

Date (mm/dd/yyyy)

INSTRUCTIONS FOR MED PLUS

For Proposed Insured age 75 & above



Questions and answers are to be asked and recorded in a consistent manner for all proposed insureds.

SECTIONS	INSTRUCTIONS
OBJECT IDENTIFICATION	<ol style="list-style-type: none">1. Point to three distinct objects and ask the proposed insured to identify the objects.2. Repeat the word given to identify each of the objects.3. Advise the proposed insured that you will ask for these words to be recalled in a few minutes.
ACTIVITY QUESTIONS	Details to any “yes” answers should be recorded in the space provided and if any of the questions 4-6 are answered “yes” complete the Assistance/Mobility Questions.
ASSISTANCE/MOBILITY QUESTIONS	Questions 7-9 are to be completed, if the proposed insured: <ul style="list-style-type: none">• does not work, volunteer or participate in an exercise program outside of the home, or• if any of the questions 4-6 are answered yes For question # 9, record the time necessary to complete this task. It should be recorded in seconds from start to finish of test.
COGNITIVE QUESTIONS	Questions are to be asked in a direct and specific manner. All answers are to be recorded as given. <ul style="list-style-type: none">• For question #2, ask the proposed insured to recall the three words from the Object Identification activity.• Specific instructions for clock drawing question #3:<ol style="list-style-type: none">1. “I am going to ask you to draw a clock”.2. “Start by drawing a circle”.3. “Place all the numbers in the circle to appear as they would on a clock”.4. “Draw the hands on the clock to represent the time, ten minutes after 11 o’clock”.5. Have the proposed insured draw the clock in the space provided.6. Have the proposed insured sign in space provided.