



## Instructions for completing the Medical Exam

### **Special Instructions for Exams on Mature Age Clients.** (Ages 71 and over)

To ensure consistency of the results from all examinations, the test results must be recorded consistently and all clients must be given the same instructions on the Mature Age questions on page 3 of the examination form.

#### **Delayed Word Recall**

Question number 19 and 21

- Ensure the client registers the three words to be recalled by both identifying the object and repeating the word.

#### **Get Up and Go Test**

Question number 22

- Underwriting assessment is based on the number of seconds it takes to complete this task. Therefore this test must be timed for the entire process and the result recorded in the space provided.

#### **Clock Drawing**

Question number 23

- The client must be given the following specific instructions:
  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. After the numbers are drawn, ask the proposed life insured to then place the hands on the clock to show the time, 10 minutes after 11 o'clock.



Medical Exam

- John Hancock Life Insurance Company (U.S.A.)
John Hancock Variable Life Insurance Company
John Hancock Life Insurance Company

(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 NB5014 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 initialed by the Proposed Life Insured.

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Policy No. (for Internal Use Only)

Proposed Life Insured

1. a) Name First Middle Last b) Date of Birth mmm dd yyyy
c) Social Security/ Tax ID Number d) Gender 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, please provide the following details

Table with columns: Product, Frequency, Current, Past, Date last used (mmm, dd, yyyy). Rows include Cigarettes, Cigars, and Other.

Family Questions

3. Have any of your immediate family members (parents, brothers and sisters) prior to age 65, died of or been diagnosed as having coronary artery disease, stroke or kidney disease? Yes No
4. Please provide the following details

Table with columns: Family History, Age, Give Details of Present State of Health, Cause of Death. Rows include Father, Mother, Brothers and Sisters.

5. a) Name and Address of Personal or Attending Doctor 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
d) List any medications (prescription or nonprescription) you are taking currently

Health Questions - Please complete Details on page 2 for Yes answers.

- 6. As far as you know, within the last 10 years have you had or been told by a doctor that you had:
a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or any other disease or disorder of the heart or arteries? Yes No
b) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? Yes No
c) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? Yes No
d) Arthritis, gout, or any bone, joint, muscle or skin disorder? Yes No
e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder? Yes No

**Health Questions (continued) - Please complete Details below for Yes answers.**

6. **As far as you know, within the last 10 years have you had or been told by a doctor that you had:**
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?  Yes  No
  - g) Prostate or testicular disease, disease of the uterus, cervix, ovaries or breasts?  Yes  No
  - h) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?  Yes  No
  - i) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?  Yes  No
  - j) Cancer or tumors?  Yes  No
  - k) An operation or admission to a hospital or any other health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance?  Yes  No
  - l) Any other health impairment or medically treated condition?  Yes  No
7. **Within the last 10 years have you:**
- a) used amphetamines, barbiturates, cannabis (marijuana), cocaine, hallucinogens, opiates or any prescription drug except in accordance with physician's instructions?  Yes  No
  - b) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use?  Yes  No
8. **Do you currently**
- a) use alcoholic beverages?  Yes  No  
 If **Yes**, describe beverages, Beverages \_\_\_\_\_, Frequency \_\_\_\_\_, Quantity \_\_\_\_\_  
 frequency and quantity  
 If **No**, have you ever used alcoholic beverages?  Yes  No  
 If **Yes**, please provide mmm dd yyyy Reason stopped \_\_\_\_\_  
 date and reason stopped
  - b) have any symptoms or medical concerns which you have not consulted a doctor or any consultation, testing or investigation recommended by a doctor which has not yet been completed?  Yes  No
9. Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No

**Details for Yes answers to Health Questions - If more space is required, use the Medical Questions Continuation Sheet, NB5034US.**

Question No.	Date			Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Doctor and Hospital
	mmm	dd	yyyy			

I, the Proposed Life Insured, authorize:

- John Hancock Life Insurance Company (U.S.A.), John Hancock Variable Life Insurance Company or John Hancock Life Insurance Company (The Company), to obtain an investigative consumer report on me.
- Any physician, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me or any minor child who is to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. In turn, The Company is free to disclose such information and any information developed during its evaluation of my application to: (a) its reinsurers; b) the MIB Inc.; (c) other insurance companies as designated by me; (d) me; (e) any physician designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc. This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original. Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

**Signatures**

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

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

Consent for Juvenile Insurance of Parent or Guardian, if other than Owner \_\_\_\_\_ Signature of Proposed Life Insured (Parent or Guardian, if under age 15) \_\_\_\_\_

Father  Mother  Guardian

I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Life Insured.

Signature of Examiner \_\_\_\_\_

\_\_\_\_\_

Name of Agent \_\_\_\_\_ Agent's Code \_\_\_\_\_

**Examiner's Report**

**Section 1 - Complete for all paramedicals and medical examinations**

10. a) Height ..... 11. Blood Pressure Readings ..... 12. Pulse .....  Regular  
Did you measure?  Yes  No ..... 1. ..... 2. ..... 3. .....  Irregular  
b) Weight ..... Systolic .....  
Did you weigh?  Yes  No .....  
c) Any weight change in the past 12 months?  Yes  No ..... Diastolic .....  
If Yes, amount of .....  
 Loss  Gain .....

13. Describe general appearance .....

14. Did anyone accompany the Proposed Life Insured during the examination? If Yes, please provide details (who it was, relationship to Proposed Life Insured and why present) .....  Yes  No

15. Did the Proposed Life Insured understand and answer all the questions asked in connection with this exam? If No, please provide details .....  Yes  No

16. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? If Yes, please provide details .....  Yes  No

**Complete 17-23 if the Proposed Life Insured is age 71 or older .**

17. a) Does the Proposed Life Insured drive? .....  Yes  No  
If No, provide details of when and why stopped .....

b) Does the Proposed Life Insured do any volunteer work or travel? .....  Yes  No  
If Yes, please provide details .....

c) Does the Proposed Life Insured use any assistive devices (cane, walker etc.) or have any gait or mobility problems? If Yes, please provide details .....  Yes  No

d) Does the Proposed Life Insured have a history of falls? .....  Yes  No  
If Yes, please provide details .....

e) Does the Proposed Life Insured have any evidence of a cognitive disorder? (dementia, memory loss, confusion, lack of comprehension, behavioral change?) .....  Yes  No  
If Yes, please provide details .....

18. a) Does the Proposed Life Insured need assistance with any of the following activities? .....  Yes  No  
 Bathing  Dressing  Eating  Transferring  Toileting  
If Yes, please provide details .....

b) Does the Proposed Life Insured need assistance with any of the following activities? .....  Yes  No  
 Cooking  House Cleaning  Laundry  Shopping  
 Meal Preparation  Handling Finances  Using the telephone  Taking Medication  
If Yes, please provide details .....

19. Delayed Word Recall - Point to three objects and ask the Proposed Life Insured to tell you what they are. Advise the Proposed Life Insured that you will be asking him/her to recall the words in a few minutes.  
Record the 3 objects: 1 ..... 2 ..... 3 .....

20. What is the: a) month ..... b) year ..... c) day of the week ..... d) day of the month ..... e) season .....

21. Ask the Proposed Life Insured to recall the words from question 19. How many were recalled correctly? ..... 13

22. Please record how long it takes for the Proposed Life Insured to complete the following task.  
Get up from seated position, walk 10 feet, return and sit again. Time: ..... seconds (for entire process)

23. Please have the Proposed Life Insured draw a clock reading 11:10.  
If more space is required for the drawing, please attach a separate page.

**Section 2 - Complete only for medical examinations.**

24. 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)

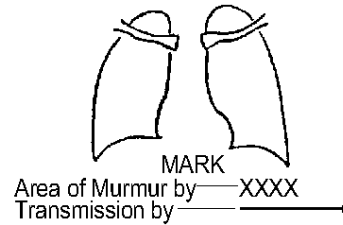
Please complete the following heart chart if any YES answers to question 24, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or a history of hypertension or heart disease.

**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**



25. On examination, is there any abnormality of:

- a) Respiratory system?  Yes  No  
 b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)?  Yes  No  
 c) Eyes, ears, nose, mouth, pharynx, head and neck (incl. hearing, vision, optic fundi, speech, thyroid)?  Yes  No  
 d) Skin, lymph nodes, peripheral arteries or veins?  Yes  No  
 e) Nervous system (incl. reflexes, weakness, gait, paralysis, tremors)?  Yes  No  
 f) Genitourinary system (incl. prostate, rectum (only if male), external genitalia)?  Yes  No  
 g) Breasts?  Yes  No  
 h) Musculoskeletal system (incl. spine, joints, amputation, deformity)?  Yes  No

26. Have you examined the Proposed Life Insured in the past year?  Yes  No

27. Is the Proposed Life Insured your private patient?  Yes  No

If Yes, please provide details of any medical history which is pertinent to the mortality risk and not already disclosed.

**Details for Yes answers to questions 25 - 26 - If more space is required, use the Medical Questions Continuation Sheet, NB5034US.**

Question No.	Date			Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Doctor and Hospital
	m/mm	dd	yyyy			

**Examiner's Report**

How did you identify the Proposed Life Insured?  Driver's License (with photo)  Other photo ID

Examination location  Examiner's Office  Proposed Life Insured's home  Proposed Life Insured's place of business

Indicate requirements completed  Blood  Urine  EKG  TST

Ticket number \_\_\_\_\_ Date sent to lab  m/mm  dd  yyyy Date sent to home office  m/mm  dd  yyyy

Indicate any requirements not completed and reason \_\_\_\_\_

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 \_\_\_\_\_

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

Examination completed on (date and time)  m/mm  dd  yyyy \_\_\_\_\_ Time \_\_\_\_\_

City, State \_\_\_\_\_ Telephone No. \_\_\_\_\_



## Notice of Disclosure of Information

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

Service Office:  
200 BLOOR STREET EAST  
TORONTO, ONTARIO  
CANADA M4W 1E5

### Proposed Life Insured

Name	First	Middle	Last

### Information Exchange

This brief description of our underwriting process is designed to help you understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others, and your right to learn the nature and substance of that information upon written request.

The purpose of the underwriting process is to make sure that you qualify for life insurance and if so, to establish the proper premium charge for that insurance. The information necessary to evaluate your application is dependent upon your age, the amount of insurance you are applying for, your medical history, your occupation, your avocations and other personal information. Your answers on the application are the principal source of information; however, additional sources of information may be required.

Information you provide will be treated as confidential. The Company may, however, make a brief report thereon to the Medical Information Bureau (MIB Inc.), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB Inc. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

**The address of the Bureau's Information Office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number (617) 426-3660.**

The Company may also release information given in your application and information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

### Investigative Consumer Report Notice

As part of our normal procedure, an investigative consumer report may be prepared concerning your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

On request to the Chief Underwriter, at the above Service Office address, we will disclose to you whether or not an investigative consumer report was done.

If an investigative consumer report was done, we will also disclose to you the nature and scope of the report, a summary of consumer rights and the name and address of the consumer reporting firm from whom you may request a copy of the report.

### Insurance Information Practices

The personal information we obtain about you is confidential and we will not disclose it to other parties without your written authorization except as permitted or required by law. You have the right to access the personal information about you that appears in our files, including any medical record information disclosed within three years of your request, unless that information relates to a claim or a civil or criminal proceeding.

However, we will normally give medical record information only to a licensed physician of your choice. You also have the right to seek correction of information about you that you believe to be inaccurate or incomplete. We will provide you with a more detailed explanation of our information practices and access and correction procedures if you send us a written request. You may do so by writing to the Chief Underwriter at the above Service Office address.

**Please give this page to the Proposed Life Insured.**



# Notice of AIDS Virus (HIV) Antibody/Antigen Testing and Consent for Testing

John Hancock Life Insurance Company (U.S.A.)

John Hancock Variable Life Insurance Company

John Hancock Life Insurance Company

(hereinafter referred to as *The Company*)

Service Office:  
200 BLOOR STREET EAST  
TORONTO, ONTARIO  
CANADA M4W 1E5

## Proposed Life Insured (Life One)

Name First Middle Last

State of Residence Date of Birth mmm dd yyyy

## Notice - Life One

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-752-AIDS.

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he/she can interpret them for you.

## Authorization and Informed Consent

(Each Proposed Life Insured must complete a separate Consent form.)

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or other person or entity.

Name of Physician or other person/entity First Middle Last

Address Street No. & Name, Suite No., City, State, Zip code

## Informed Consent

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

Signed at City State This Day of Year

Signature of Proposed Life Insured

X

**Company Copy - Please provide the Proposed Life Insured with a copy.**



# Notice of AIDS Virus (HIV) Antibody/Antigen Testing and Consent for Testing

John Hancock Life Insurance Company (U.S.A.)

John Hancock Variable Life Insurance Company

John Hancock Life Insurance Company

(hereinafter referred to as *The Company*)

Service Office:  
200 BLOOR STREET EAST  
TORONTO, ONTARIO  
CANADA M4W 1E5

## Proposed Life Insured (Life Two)

Name First Middle Last

State of Residence Date of Birth mmm dd yyyy

## Notice - Life Two

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-752-AIDS.

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he/she can interpret them for you.

## Authorization and Informed Consent

(Each Proposed Life Insured must complete a separate Consent form.)

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or other person or entity.

Name of Physician or other person/entity First Middle Last

Address Street No. & Name, Suite No., City, State, Zip code

## Informed Consent

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

Signed at City State This Day of Year

Signature of Proposed Life Insured

X

**Company Copy - Please provide the Proposed Life Insured with a copy.**