



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

Policy No. (for Internal Use Only)

### 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.

#### 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

Product	Frequency	Current	Past	Date last used		
				mmm	dd	yyyy
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. 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

Family History	Age	Give Details of Present State of Health	Family History	Age	Cause of Death
L I V I N G	Father		D E C E A S E D	Father	
	Mother			Mother	
	Brothers and Sisters			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  
 mmm dd yyyy

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.) 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.

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)

- X**  
 Father  Mother  Guardian

**X**

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

Signature of Examiner

**X**

Name of Agent

Agent's Code



**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  
(e.g. shortness of breath, edema, stasis dermatitis, PVD)

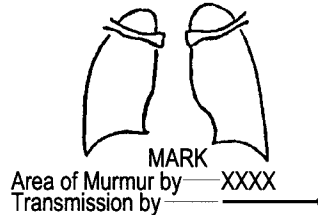
Please complete the following heart chart if any YES answers to question 24, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or a history of hypertension or heart disease.

**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
	mmm	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 mmm dd yyyy Date sent to home office mmm 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

Examination completed on (date and time) mmm dd yyyy Time

Other: \_\_\_\_\_

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



# Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen 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

To determine your insurability, the Insurer has requested that you provide a sample of your blood, oral fluids or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood, oral fluids or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood, oral fluids or urine abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

## Consent

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

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle or the submission of oral fluids or urine sample, the testing of that blood, oral fluids or urine sample and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signed at	City	State	This	Day of	Year
Signature of Proposed Life Insured					
<b>X</b>					

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

**(See next page)**