

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

Policy No.

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- This form is part of the application for life insurance for the Proposed Life Insured.
- Notice of Disclosure of Information form NB0780 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.

Agent's Name _____ Agent's Code _____

Proposed Life Insured

1. a) Name _____ (first, middle, last) c) Place of Birth _____
 b) Date of Birth _____ (mmm/dd/yyyy) d) Social Security / Tax ID No.

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Smoking Questions

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? No Yes - give details in the chart:

Product	Frequency	Current	Past	Date last used
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"/>	

Health 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? No Yes

4. **Family History**

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

5. a) Your Height _____ b) Your Weight _____
 c) Have you had a loss of weight of more than 10 pounds within the past 12 months? No Yes - state how much and reason: _____

6. a) Name and address of personal or attending doctor _____

 _____ b) Telephone _____

c) Date last consulted _____

Reason and any medication/treatment given _____

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

Health Questions (continued) Please complete Details below for "Yes" answers

7. So 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 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
 - 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, 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
8. Within the last 10 years have you:
- a) used narcotics, amphetamines, cocaine or any prescription drug except in accordance with physician's instructions? Yes No
 - b) undergone treatment or been advised by a doctor, licensed practitioner, or any organization regarding alcohol or drug use? Yes No
 - c) used alcoholic beverages? If yes, describe frequency and quantity _____ 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 Questions Continuation Sheet.)

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

Authorization to Obtain Information

I, the Proposed Life Insured, authorize:

1. The Manufacturers Life Insurance Company (U.S.A.) (The Company), to obtain an investigative consumer report on me.
2. Any physician, medical care provider, hospital, clinic, laboratory, insurance company, the MIB Inc. (Medical Information Bureau) or any other similar person or organization to give The Company and its reinsurers information about me.

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 _____ this _____ day of _____ Month _____ Year

(X)

Signature of Proposed Life Insured (Parent or Guardian, if under age 10)

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

(X)

Signature of Examiner

Examiner's Report

Name of Proposed Life Insured (PRINT) _____

Section 1 Complete for all paramedicals and medical examinations

Height _____ Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulse: <input style="width:50px;" type="text"/> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Type of irregularity _____ If extra systoles, No. per min. _____	Blood Pressure Readings: (3 Readings) <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"></td> <td style="width:33%; text-align: center;">Sitting</td> <td style="width:33%; text-align: center;">Sitting</td> <td style="width:33%; text-align: center;">Lying</td> </tr> <tr> <td style="text-align: center;">Systolic</td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> </tr> <tr> <td style="text-align: center;">Diastolic</td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> <td style="text-align: center;"><input style="width:40px; height:20px;" type="text"/></td> </tr> </table>		Sitting	Sitting	Lying	Systolic	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>	Diastolic	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>
	Sitting	Sitting	Lying											
Systolic	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>											
Diastolic	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>	<input style="width:40px; height:20px;" type="text"/>											

10. Describe the Proposed Life Insured's general appearance (e. g, vigorous and healthy, pale, sickly, etc.) _____
11. Did anyone accompany the Proposed Life Insured during the examination? Yes No
 If "Yes", please provide details (including who the person was and why he/she was present) _____
12. Was the Proposed Life Insured able to understand and to answer all questions asked in connection with this examination? Yes No
 If "No", please provide details. _____
13. Do you suspect anything unfavourable such as excessive use of alcohol, cigarettes, or drugs? If "Yes", please provide details. _____ Yes No
14. Which of the following did you use to identify the Proposed Life Insured? Driver's License with picture Other picture ID - _____

Complete if the Proposed Life Insured is over the age of 65

15. a) Does he/she exercise? Yes No
 If "Yes", please provide details including exercise capacity, type and frequency. _____
- b) If retired, does he/she do any volunteer work or have any hobbies? Yes No
 If "Yes", please provide details. _____
- c) Does he/she have any gait or mobility problems? Yes No
 If "Yes", please describe. _____
- d) Does he/she have any evidence of a cognitive disorder (e.g. Dementia, memory loss)? Yes No
 If "Yes", please provide details. _____

Do not ask the following questions, if he/she works, volunteers or participates in an exercise program outside of the home.

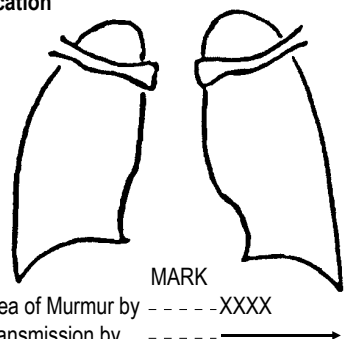
16. a) Does he/she need assistance with any instrumental activities of daily living (e.g. banking, shopping)? Yes No
 If "Yes", please provide details. _____
- b) Does he/she need assistance with any activities of daily living (e.g. feeding, bathing, dressing)? Yes No
 If "Yes", please provide details. _____

Section 2 Please complete only for medical examinations

Cardiovascular System

17. (a) Any extra or abnormal heart sounds? Yes No
 (b) Murmurs? Yes No
 (c) Any increased heart size? Yes No
 (d) Inadequate circulation anywhere - shortness of breath, edema, stasis dermatitis, peripheral vascular disease? Yes No

Please complete heart chart below if there are any "Yes" answers to question 17 or if there is any pulse irregularity or 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" on Page 4:	<input type="checkbox"/> None <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic Grade I II III IV V VI <input type="checkbox"/> Loud <input type="checkbox"/> Harsh <input type="checkbox"/> Rough <input type="checkbox"/> Soft <input type="checkbox"/> Blowing	Location
Is it heard	At rest? <input type="checkbox"/> Yes <input type="checkbox"/> No After exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No On full inspiration? <input type="checkbox"/> Yes <input type="checkbox"/> No On full expiration? <input type="checkbox"/> Yes <input type="checkbox"/> No Erect? <input type="checkbox"/> Yes <input type="checkbox"/> No Lying down? <input type="checkbox"/> Yes <input type="checkbox"/> No Left lateral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there any Hypertrophy? If so, provide details:	

- | | | |
|-------------------------|--|---|
| Signs of Failure | Shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cyanosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Engorgement of neck veins? <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of ankles? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rales at lung bases? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-------------------------|--|---|

(See next page)

Section 2 (continued) Please complete only for medical examinations

On examination, is there any abnormality of:

- 18. Respiratory system? Yes No
- 19. Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)? Yes No
- 20. Eyes, ears, nose, pharynx, head and neck (incl. hearing, vision, optic fundi, speech, thyroid)? Yes No
- 21. Skin, lymph nodes, peripheral arteries or veins? Yes No
- 22. Nervous system (incl. reflexes, weakness, gait, paralysis, tremors)? Yes No
- 23. Breasts? Yes No
- 24. Genito-urinary system (incl. prostate, rectum, external genitalia)? Yes No
- 25. Musculo-skeletal system (incl. spine, joints, amputation, deformity)? Yes No
- 26. Are you the attending physician? If "Yes", please include a summary of your file information and statement of your additional fee. Yes No

Details for "Yes" answers to Health Questions

Summary of File Information and Statement of Fee

Date _____ Time _____ Examined at: My Office Applicant's home Applicant's place of business

Examiner's Name: _____ Fee: _____

Address: _____

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5**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 under the rules of The Company and, assuming you do, establish the proper premium charge for that insurance. The underwriting process assures that the cost of insurance is distributed equitably among all policyowners, and that each individual pays his or her fair share.

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 (M.I.B.), 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, M.I.B. 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. Medical information will be disclosed only to your attending physician. 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 interview 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 you may contact to inspect or request a copy of the report.

GIVE THIS PAGE TO THE PROPOSED LIFE INSURED