

PACIFIC LIFE INSURANCE COMPANY

Life Insurance Operations Center
P.O. Box 6390 • Newport Beach, CA 92658-6390
(800) 347-7787



PACIFIC LIFE

APPLICATION, PART II - MEDICAL

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

1. Full Name
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:
b. Date: MO. YR
c. Reason consulted:

d. Did any symptoms prompt consultation?
e. Was any treatment given or medication prescribed?
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:
5. a. Have you within the past 5 years been a patient in a hospital, clinic, sanitarium, or other medical facility?
6. a. Except as prescribed by a physician, have you used heroin, morphine, or other narcotic drugs in the last 10 years?
7. Other than as stated in answers above, have you within the past 5 years:
8. Have you had any change in weight in the past year?
9. Have either of your parents, brothers, or sisters had diabetes, cancer, high blood pressure, heart disease, or mental illness?

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?
b. If "Yes" how many a day?
c. Did you ever smoke cigarettes?
d. If "Yes" on 11(c), give date last cigarette smoked:
e. Do you use tobacco in any other form?
f. Have you used tobacco in any other form within the last 24 mos.?

10. Parents' Record (COMPLETE BELOW):
Table with columns: IF LIVING (AGE, STATE OF HEALTH), IF DECEASED (AGE AT DEATH, CAUSE OF DEATH). Rows for Father and Mother.

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. SIGNATURE OF PROPOSED INSURED

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)

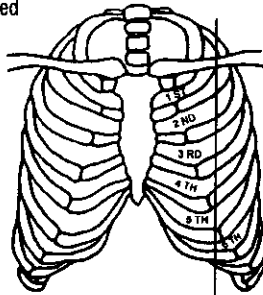
14. PULSE Rate Irregularities Per Min.	At Rest	After Exercise	3 Minutes Later

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
 Transmitted Systolic Apical Soft (Gr. 1-2)
 Localized Presystolic Basal Mod. (Gr. 3-4)
 Diastolic Other 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)

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

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

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:

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 Hyphens →

Examined at

My Office Other: _____

Date and Hour of Examination _____ A.M.
 _____ P.M.

EXAMINER'S NAME AND OFFICE ADDRESS (PLEASE PRINT)

Name _____

Street _____

City _____

State _____

Name of Agent Requesting Examination
 Mail To: Pacific Life Insurance Company
 Risk Selection Dept. - Med. Fee Desk
 P.O. Box 6390
 Newport Beach, CA 92658-6390

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**PACIFIC LIFE****HIV CONSENT FORM - CALIFORNIA****HIV ANTIBODY TESTING CONSENT FORM**

To evaluate your insurability, the insurer may request a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. This test is a three-step protocol (ELISA, ELISA AND WESTERN BLOT). A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. A test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, the County Department of Health, the State Department of Health Services, local medical societies, or alternative test sites can provide you with further information on the medical implications of a positive test.

A positive HIV antibody test will result in your application for insurance being declined.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should contact the AIDS Counseling Resource Office in your area. These offices are listed below:

San Francisco AIDS Foundation, 25 Van Ness Ave., Suite 660, San Francisco, California 94102,
 (415) 864-5855

Sacramento AIDS Foundation, 1900 K Street, Suite 201, Sacramento, California 95814, (916) 448-2437

Central Valley AIDS Team, P. O. Box 4640, Fresno, California 93744, (209) 264-2436

AIDS Project Los Angeles, 3670 Wilshire Blvd., Suite 300, Los Angeles, California 90010, (213) 380-2000

AIDS Services Foundation of Orange County, 1685-A Babcock St., Costa Mesa, California 92627,
 (714) 646-0411

San Diego AIDS Project, 3777 Fourth Ave., San Diego, California 92103, (619) 543-0300

AIDS Project - East Bay, 400 40th Street, Suite 20, Oakland, California 94609, (415) 420-8181

ARIS Project, 595 Millich Drive, Suite 104, Campbell, California 95008, (408) 370-3272

If your test results are negative, no routine notification will be sent to you. The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. You should request that your results be sent to your private physician so that he can interpret them for you. If you do not have a personal physician and you wish to receive the results directly, we strongly urge you to contact one of the AIDS Counseling offices listed above, or the County Department of Health.

In the event of a positive or indeterminate test result, I authorize disclosure to my personal physician:

PHYSICIAN'S INFORMATION	Name: First _____ MI _____ Last _____
	Address _____
	City _____ State _____ Zip Code _____

INFORMED CONSENT

I have read and understand this information. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, 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 form. A photocopy is as valid as the original. For my information, I have been given the brochure "The Truth About HIV and AIDS" information obtained by the American Red Cross.

Print Proposed Insured's Name: First _____ MI _____ Last _____	
Proposed Insured or Parent/Guardian's Signature _____	Date _____

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.