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

PACIFIC LIFE

# MED PLUS

For Proposed Insured age 76 & above

| **Proposed Insured's Name: First** | **MI** | **Last** | **Date of Birth** (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| **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:<br>a. ____________ b. ____________ c. ____________ | | |
| **ACTIVITY QUESTIONS** | | **Yes** | **No** |
| | 1. Do you exercise?<br>If **yes**, provide details including exercise capacity and frequency in Remarks section. | ☐ | ☐ |
| | 2. Do you work outside the home, do any volunteer work, or travel?<br>If **yes**, provide details in Remarks section | ☐ | ☐ |
| | 3. Do you drive?<br>If **no**, provide details of when and why stopped in Remarks section. | ☐ | ☐ |
| | 4. Do you have any gait or mobility problems?<br>If **yes**, provide details in Remarks section. | ☐ | ☐ |
| | 5. Do you<br>A. use any assistive device (cane, walker, etc.)?<br>B. have a history of falls?<br>If **yes**, provide details in Remarks section. | ☐<br>☐ | ☐<br>☐ |
| | 6. Have you been diagnosed with any cognitive disorder (dementia, memory loss, confusion, lack of comprehension, behavioral change)?<br>If **yes**, provide details in Remarks section. | ☐ | ☐ |
| **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?<br>(If **yes**, select which activities require assistance and provide details in the Remarks section)<br>☐ Bathing; ☐ Dressing; ☐ Eating; ☐ Transferring; ☐ Toileting | ☐ | ☐ |
| | 8. Do you need assistance with any activities of daily living?<br>(If **yes**, select which activities require assistance and provide details in the Remarks section)<br>☐ Cooking; ☐ House Cleaning; ☐ Laundry; ☐ Shopping; ☐ Meal Preparation;<br>☐ Handling Finances; ☐ Using the telephone; ☐ Taking Medication | ☐ | ☐ |
| | 9. Record how long it takes for the Proposed Insured to complete the following task.<br>Get up from seated position, walk 10 feet, return and sit again. Time: __________seconds (for entire process) | | |

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**



15-27351-00 10/2006

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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:

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** |

SIGN HERE

X ________
**Examiner's Signature**

________
**Date** (mm/dd/yyyy)