

THE CANADA LIFE ASSURANCE COMPANY

The Canada Life Assurance Company

Canada Life Insurance Company of America

6201 Powers Ferry Rd., NW Atlanta GA 30339
(770) 963-1969

PART II B

MEDICAL EXAMINATION

Questions to be answered by the Proposed Insured and recorded by examiner.

1) Proposed Life Insured	First	Middle	Last	Sex	Date of Birth
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2) Usual Personal Medical Advisor: _____

Address: _____

Date, reason last consulted: _____ Treatment or medication: _____

3) Family History-Indicate any family history of diabetes, heart disease, cancer or any other hereditary disease:

	Family History or Cause of Death	Age if Living	Age at Death
Father			
Mother			
Siblings			

- | | |
|---|--|
| <p>4) Have you ever had or been treated for:</p> <p>a) Disease or disorder of the eyes, ears, nose or throat? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Asthma, persistent hoarseness, blood spitting, Bronchitis, emphysema, tuberculosis or other Respiratory disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Chest pain or discomfort, abnormal blood pressure, Breathlessness, heart murmur or any problems with Your heart, veins or blood circulation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>d) Ulcers, jaundice, hepatitis, gall bladder or liver Disease, intestinal bleeding, chronic diarrhea, other Disorder of the bowel? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>e) Venereal disease, albumin, sugar, blood or pus in The urine, or other kidney or urinary problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>f) Amputation, deformity, arthritis, or any problems With your back or neck, muscles, bones, joints or Spine? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>g) Dizziness, fainting, recurrent headaches, Convulsions, paralysis, stroke, or other disorder of The nervous system? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>h) Nervous anxiety, depression or any other mental Disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>i) Disease of skin, cancer, tumor, anemia, hemophilia Or any other disorder of the blood or lymph glands? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>j) Diabetes or a disorder of thyroid or other endocrine Glands? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>k) Disorder of the breasts or reproductive organs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>5) Have you:</p> <p>a) Ever been tested or treated by a medical Professional for significant weight loss, fever, night Sweats, persistent diarrhea, or swollen lymph nodes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) In the last 10 years, been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other than the above, have you within the past five</p> <p>a) Had any mental or physical disease or disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Consulted a physician or other practitioner? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Been a patient in a hospital, clinic or other medical <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>d) Had an electrocardiogram, X-ray, blood (other Than an HIV test), or other diagnostic test? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>e) Been advised to have an investigation, hospitalization Or surgery which has not been complete? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6) Has your weight changed more than 10 pounds in the Year? If yes, amount _____ per week, type _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7) Do you now or have you ever used alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>a) If yes, amount _____ per week, type _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Have you had any problem, received treatment or Advice or belonged to an organization because of Alcohol use? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8) During the past five years, have you used heroin or Narcotics, hallucinogenic or other habit forming drugs, Including cocaine and marijuana? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|---|--|

SPACE FOR DETAILS OF 'YES' ANSWERS. Underline history, Symptoms or Disease. Identify question by number. Give Dates, Severity, Duration and Outcome. State Names and Addresses of all Attending Physicians, Hospitals, Clinics, Sanatoria and other Medical Facilities.

SPACE FOR DETAILS OF "YES" ANSWERS (continued)

AUTHORIZATION TO OBTAIN INFORMATION

The answers recorded above are given by me and are, to the best of my knowledge and belief, complete and true.

1. To determine my eligibility for insurance, I authorize the release of information concerning:
 - a. the diagnosis, treatment or prognosis of any past or present:
 - 1) physical or mental condition; and
 - 2) drug or alcohol condition; and
 - b. any non-medical data which relates to insurability.
2. The parties authorized to release such information are:
 - a. any physician or medical practitioner;
 - b. any hospital, clinic or other medically related facility;
 - c. any insurance or reinsurance company;
 - d. the Medical Information Bureau or any consumer reporting agency; and
 - e. any employer of those proposed for insurance.
3. The information may be released to:
 - a. Canada Life Assurance Company (Canada Life);
 - b. the reinsurers of Canada Life; and
 - c. the legal representative or any agent of Canada Life.
4. Any data obtained will not be released by Canada Life to any person or organization except:
 - a. to reinsuring companies;
 - b. to the Medical Information Bureau;
 - c. to persons performing business or legal services in connection with my application;
 - d. to any physician named in my medical declarations (as required for my medical care);
 - e. as required by law; or
 - f. as I further authorize.

I agree that a photocopy of this authorization will be as valid as the original.

I know that I may request a copy of this authorization.

I agree that this authorization shall be valid for 26 months from the date shown below.

I know that I may revoke this authorization at any time except to the extent that action is taken in relying on it.

DATED AT _____ THIS _____ DAY OF _____.

WITNESS

Signature of Proposed Life Insured

PART III - Questions 1 to 6 to be answered by all Examiners

1. Examination authorized by _____

2. General Appearance of Applicant _____

3. Acquaintance with Applicant Patient Business Social Stranger

4. Height (in shoes) _____ Did you measure? Yes No
 Weight (in ordinary clothes) _____ Did you weigh? Yes No
 Chest Circumference: Full inspiration _____ Full expiration _____
 Abdomen at Umbilicus _____ Ins.

5. Pulse and Blood Pressure

Take seated, relaxed, diastolic blood pressure at 5th point of disappearance of all sound. If pulse rate is over 90 or under 50, or if blood pressure exceeds 140 Systolic or 90 Diastolic, take two additional readings after a further period of rest.

Pulse per Minute	Initial Reading	2nd Reading	3rd Reading
Blood Pressure			

6. URINALYSIS: Specific Gravity _____ Albumin _____ Sugar _____

Important: In addition to your urinalysis, please send specimen to Head Office and confirm that specimen has been sent.

Questions 7, 8, 9, 10 AND 11 are to be answered only by a Physician. For applicants 76 years and older questions 12 through 19 should be completed by the examining nurse or physician.

Give full details of "Yes" answers in the space provided below

7. (a) Do you find any evidence of past or present disease or impairment of the heart and cardiovascular system? Yes No

If "Yes", indicate on the diagram the position of the apex beat and any murmurs. Please describe any murmurs fully.

(b) Are any peripheral pulses absent? Yes No

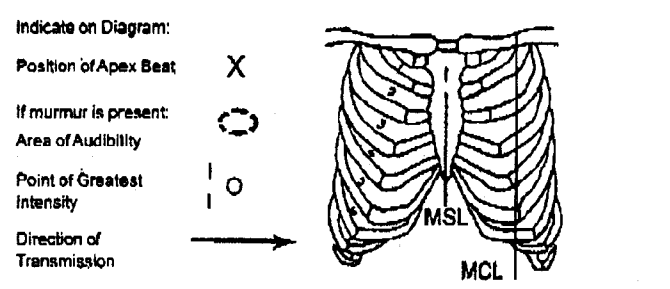
(c) Is there any cardiac enlargement? Yes No

(d) Are there any arrhythmias? If so please describe Yes No

(e) Is there any cyanosis, dyspnoea, or oedema? Yes No

(f) Is there any evidence of varicose veins or phlebitis? Yes No

(g) Cardiac diagnosis (if any) Yes No



Are any murmurs present? Yes No

If "Yes", describe:

(a) Audibility: Erect Recumbent Lt. Lateral
 Aortic Pulmonary Tricuspid
 Mitral Other

(c) Timing: Systolic Diastolic Prestolic
 (d) Intensity: Faint Moderate Loud

(e) Effect of Exercise: Increased Decreased
 Disappearance Unchanged

(f) Quality: Soft Blowing Harsh
 Transmitted: Yes No

(h) Type of murmur: Functional Organic
 (If Organic, give Diagnosis)

Effect of suitable exercise sufficient to increase pulse rate at least 100 (e.g. 20 vigorous toe touches)

	Pulse	Extrasystoles
Resting		
Immediately after		
2 minutes after		
5 minutes after		

8. Do you find any evidence of past or present disease or impairment of:

(a) The Eyes and Vision? Yes No

(b) The Ears and Hearing? Yes No

(c) The Chest and Respiratory System? Yes No

(d) The Gastrointestinal System, including rectal exam? Yes No

(e) The Kidneys and Genitourinary System? Yes No

(f) The Brain and Nervous System? Yes No

(g) The Endocrine or Lymph System? Yes No

(h) The Spine and Extremities? Yes No

(i) The Skin? Yes No

9. Any deformities or operative scars? Yes No

10. Have you any reason to think that the Applicant has been intemperate in the use of alcohol or addicted to habit-forming drugs? Yes No

11. Do you consider the applicant to be in good health physically and mentally? Yes No

This section is to be completed by the examining nurse or physician for all applicants aged 76 years or older.

Mobility Yes No

12. Does the proposed use a cane or walker, or have any difficulty ambulating or transferring? Yes No

Please describe: _____

13. Has the applicant suffered any falls within the past year? Yes No

If yes - how many falls? _____

How long did it take to get up from the falls? (describe the longest lay in minutes) _____

14. Ask the applicant to get up out of the chair, walk at least 10 feet, turn around and sit down in the same chair. Observe and record the performance. Discretely time the task from start to finish and record in seconds. _____

Did the applicant use an aid to perform the get up and go test? Yes No

Indicate aid used: _____

If the client was unable to do this test please indicate why. _____