

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)
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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: a. _____ b. _____ c. _____		
ACTIVITY QUESTIONS	Yes	No
1. Do you exercise? If yes , provide details including exercise capacity and frequency in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you work outside the home, do any volunteer work, or travel? If yes , provide details in Remarks section	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you drive? If no , provide details of when and why stopped in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any gait or mobility problems? If yes , provide details in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you A. use any assistive device (cane, walker, etc.)? B. have a history of falls? If yes , provide details in Remarks section.	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
6. Have you been diagnosed with any cognitive disorder (dementia, memory loss, confusion, lack of comprehension, behavioral change)? If yes , provide details in Remarks section.	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No
7. Do you need assistance with any of the following activities? (If yes , select which activities require assistance and provide details in the Remarks section) <input type="checkbox"/> Bathing; <input type="checkbox"/> Dressing; <input type="checkbox"/> Eating; <input type="checkbox"/> Transferring; <input type="checkbox"/> Toileting	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you need assistance with any activities of daily living? (If yes , select which activities require assistance and provide details in the Remarks section) <input type="checkbox"/> Cooking; <input type="checkbox"/> House Cleaning; <input type="checkbox"/> Laundry; <input type="checkbox"/> Shopping; <input type="checkbox"/> Meal Preparation; <input type="checkbox"/> Handling Finances; <input type="checkbox"/> Using the telephone; <input type="checkbox"/> Taking Medication	<input type="checkbox"/>	<input type="checkbox"/>
9. Record how long it takes for the Proposed Insured to complete the following task. Get up from seated position, walk 10 feet, return and sit again. Time: _____seconds (for entire process)		

REMARKS – IDENTIFY QUESTION AND GIVE DETAILS

