Confidential Medical Questionnaire

Please PRINT clearly.

MEDICAL QUESTIONNAIRE – INSTRUCTIONS

Please follow these instructions closely. The information obtained is important for the person being examined.

- All recorded answers must be in English.
- If any party to this examination has a personal or professional relationship to the Client, please do not proceed.
- Part 1 and Part 2 may be completed by the Examining Physician, Physician's Assistant or Nurse; Part 3 must be completed by the Nurse or Examining Physician (i.e., Cardiologist, Internist, or General Practitioner). Part 4 must be completed by the Examining Physician (i.e., Cardiologist, Internist, or General Practitioner). Part 4 is NOT completed for Paramedical exams.
- Review the person's original identity document(s) and record the information on Part 1 of this form. Attach a certified copy of the identity document(s) with this questionnaire.
- Review the person's medical history, list condition(s), and record the information on Part 2 of this form. Please ask the medical history questions as they are written and record the answers as given in full detail.
- Perform the physical examination to determine the person's current health status and record the information on Part 3 and Part 4 of this form. Please pay particular attention to any vital signs or other results of the examination that relate to the person's medical history. Laboratory tests to complete the examination are not listed on this form but will be provided separately.
- If the Client requires the assistance of a translator or interpreter, please have the Interpreter Services Declaration completed by both the Client and the interpreter.

PART 1. PROPOSED INSURED INFORMATION (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy)

Passport or government identity document of person examined:

Type of Identification	Passport Number or Government ID Number
Country of Issue	Date of Expiration (dd/mm/yyyy)

Please attach a **legible** certified copy of the identity document of person being examined.

Are you satisfied as to the identity of the person being examined? ..... ☐ Yes ☐ No

IF YOU ARE NOT SATISFIED AS TO THE PERSON'S IDENTITY, OR HE OR SHE IS UNABLE TO PROVIDE SATISFACTORY IDENTIFICATION, PLEASE DO NOT PROCEED WITH EXAMINATION OR TESTING.

Family Name/Last Name of Examiner	Given Name/First Name of Examiner
Examiner Address	
Examiner Signature X	Date (dd/mm/yyyy)

PART 2. PERSONAL HEALTH HISTORY (to be completed by Examining Physician, Physician's Assistant or Nurse)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	Date of Birth (dd/mm/yyyy)

Please circle the specific condition for which any "Yes" answer is given.

A. Have you ever been treated for or had any symptoms or indication of:

1. High blood pressure, high cholesterol, angina, chest pain, heart attack, coronary artery disease, heart murmur, irregular heartbeat, transient ischemic attack (TIA), stroke or cerebrovascular accident (CVA), blood clot(s), peripheral vascular disease (poor circulation), aneurysm, or any other disease or disorder of the heart or blood vessels? ..... ☐ Yes ☐ No

2. Anemia, hemophilia, or any other blood or bleeding disease or disorder? ..... ☐ Yes ☐ No

3. Asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic or recurrent bronchitis, sleep apnea, sarcoidosis, cystic fibrosis, tuberculosis, persistent cough, hoarseness, shortness of breath or difficulty breathing, or any other respiratory disease or disorder? ..... ☐ Yes ☐ No

4. Chronic anxiety, depression, burnout, chronic fatigue syndrome, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), eating disorder, schizophrenia, attempted suicide, any other psychological, emotional or nervous disease or disorder? ..... ☐ Yes ☐ No

5. Hepatitis (including hepatitis carrier state), cirrhosis, jaundice, Crohn's disease, ulcerative colitis, irritable bowel syndrome, diverticulitis, persistent diarrhea, rectal or intestinal bleeding, ulcer (peptic or gastric), pancreatitis, or any other disease or disorder of the bowel, stomach, pancreas or liver? ..... ☐ Yes ☐ No

6. Diabetes, gestational diabetes, abnormal blood sugar, goiter, hyperthyroidism, hypothyroidism, lymph or gland disease or disorder, or any other thyroid, pituitary or endocrine disease or disorder? ..... ☐ Yes ☐ No

7. Lupus, scleroderma, arthritis, fibromyalgia, muscular dystrophy, paralysis, or any other disease or disorder of the skin, connective tissue, muscles, joints, limbs, back or bones? ..... ☐ Yes ☐ No

Provide details to "Yes" answers in Section Q on page 6.

PART 2. PERSONAL HEALTH HISTORY (continued)

8. Cancer, leukemia, lymphoma, melanoma, dysplastic nevus (atypical mole), basal cell carcinoma, tumor, cyst(s), polyp(s), any other growths or malignancy? ☐ Yes ☐ No

9. Abnormal prostate specific antigen (PSA), prostatitis or any other prostate disease or disorder, breast lump(s) or cyst(s), abnormal mammogram or pap smear, hysterectomy, disease or disorder of the ovary or uterus, sexually transmitted disease, disease or disorder of the genital organs, kidney stone(s), nephritis, urinary tract infection, sugar, blood or protein in the urine, or any other kidney or bladder disease or disorder? ☐ Yes ☐ No

10. Autism, cerebral palsy, Down syndrome, developmental delay, epilepsy or seizure(s), multiple sclerosis (MS), loss of balance, consciousness, sensation or speech, coma, concussion, severe headaches(s), dizziness, fainting, Parkinson's disease, tremor, Alzheimer's disease, dementia or cognitive impairment, amyotrophic lateral sclerosis (ALS), or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

11. Any disorder of the eyes (excluding any vision impairment corrected with glasses or contact lenses), ears, nose, throat or mouth? ☐ Yes ☐ No

B. Have you ever been tested for or has anyone ever recommended that you be tested for exposure to the HIV (AIDS) virus? ☐ Yes ☐ No

C. Have you ever been treated for or had any indication of AIDS, HIV infection or any other disease or disorder of the immune system? ☐ Yes ☐ No

D. Have you ever had a blood transfusion? ☐ Yes ☐ No

E. Other than for conditions already disclosed, in the last 5 years, have you had any medical or diagnostic tests, such as X-rays, ECG, scans, MRI, ultrasounds, biopsies or blood tests? ☐ Yes ☐ No

F. Have you been hospitalized or had any surgery in the last 10 years? ☐ Yes ☐ No

G. Do you have any symptoms for which you have not yet consulted a physician or received treatment? ☐ Yes ☐ No

H. Other than for conditions already disclosed, has a doctor recommended any tests or referrals that have not yet been completed, or are you currently awaiting test results? ☐ Yes ☐ No

I. Do you have a deformity or an amputation? ☐ Yes ☐ No

J. Are you taking any prescribed or non-prescribed medications? ☐ Yes ☐ No

K. Have you ever used tobacco or nicotine products in any form (including but not limited to cigarettes, cigars, cigarillos, pipe, chewing tobacco, vapour products, marijuana, nicotine patches, nicotine gum, hookah, e-cigarettes or shisha)? ☐ Yes ☐ No

If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

L. In the last 10 years have you used cocaine, LSD or other psychoactive drugs, heroin, or other narcotics? ☐ Yes ☐ No

If "Yes," provide details:

Product(s)	Amount(s) and frequency of use	Date(s) last used (dd/mm/yyyy)

PART 2. PERSONAL HEALTH HISTORY (continued)

M. Do you currently drink alcohol? ☐ Yes ☐ No

If "Yes," which of the following best describes the average frequency of your alcohol consumption?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once per month

On those days when you drink alcohol, how many drinks do you typically have? _____

N. Have you ever received treatment or been advised to reduce use or frequency of use, seek treatment, counseling or medical advice due to your use of drugs or alcohol? ☐ Yes ☐ No

If "Yes," indicate the type of counseling or treatments, and dates started and ended (include any participation in organizations/support groups) in Section Q on page 6.

O. Family History

1. Have any of your biological parents, brothers or sisters ever been diagnosed with heart disease, stroke or transient ischemic attack (TIA), cancer, diabetes, Parkinson's disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's disease, or any other hereditary disease or disorder? ☐ Yes ☐ No

If "Yes," complete the following chart:

Your relationship to family member	Condition (if cancer include type)	Age at onset	Age if living	Age at death

2. Please provide current age or age at death and cause of death of remaining family members not recorded above:

Family Member	Current Age	or Age at Death and Cause of Death
Mother		
Father		
Brothers		
Sisters		

PART 2. PERSONAL HEALTH HISTORY (continued)

P. Medical Advisor/Clinic/Hospital Information

Do you have a personal care physician? ☐ Yes ☐ No

If "Yes," provide details below:

Name of personal physician, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)		Date last visited	
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

If you have no personal physician or health care advisor, please provide details of why you last consulted any medical clinic, health care advisor or hospital. This includes details of any health screening exams.

Name of medical doctor, medical clinic, health care advisor or hospital last consulted			
Street Address			
City	State/Province	Country	Postal Code
Name on file (if different than legal name)		Date last visited	
Reason for last medical consultation			
Treatment or medication prescribed and results of any tests completed			

PART 2. PERSONAL HEALTH HISTORY (continued)

Q. Please give details for "Yes" answers to any of the questions on pages 2 - 5.

Please reference the question number and provide details, including the date of occurrence, the impairment, and the name and address of doctors, medical clinics, health care advisors and hospitals. For health screening exams, provide details including date of test(s), type of test(s), the results and the name and address of doctor, health care advisor and medical facility.

Question number	Date (dd/mm/yyyy)	Details	Name and address of doctors, medical clinics, health care advisors and hospitals

PART 2. PERSONAL HEALTH HISTORY (continued)

Question number	Date (dd/mm/yyyy)	Details	Name and address of doctors, medical clinics, health care advisors and hospitals

I declare and represent to the life insurance company that my answers provided in this Medical Questionnaire are complete, correct, and true to the best of my knowledge and belief. I understand and acknowledge that my answers, as recorded in this Medical Questionnaire, together with all ancillary forms and information as may be required by the insurance company, will form the basis for life insurance coverage and that all such documents may be incorporated as part of any policy or certificate issued which provides life insurance coverage on my life. I understand that if I misrepresent any of my answers or statements or fail to provide all relevant information in complete detail, that may result in benefits being contested by any company which provides me with life insurance coverage and the policy may be voided.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information for the following purposes: (a) to process and evaluate an application, transaction, or request related to life insurance, annuity, investment account, or other product or service we may offer (any of which referred to here for convenience as "your policy"), (b) to underwrite an application for your policy, (c) to administer claims and determine or fulfill responsibility for coverage and provision of benefits, (d) to administer coverage, benefits, and other features provided by your policy, (e) to obtain reinsurance, or (f) for any other legally permissible purpose related to your policy provided by the Company. The undersigned hereby consents to the collection, use, and disclosure of his or her personal information by the Company for the purposes described above.

The Company may disclose your personal information to reinsurers, affiliates, third party service providers and agents of the Company who may be engaged to assist with the administration of your policy, to carry out the above purposes, to professional advisors, and otherwise as may be required or permitted by applicable law and the Company's privacy statement. You may obtain a copy of the Company's privacy statement from your Financial Representative.

NOTE: If the proposed insured is under age 18 then the signature of a parent or legal guardian is required in the space provided below.

Signature of Person Examined X	Date (dd/mm/yyyy)
Signature of Parent/Legal Guardian (please circle which applies) X	Date (dd/mm/yyyy)

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information to process and evaluate an application, transaction, request, or administer coverage in connection with, life insurance, annuity, investment account, or other product or service the Company may offer or issue to a client, or for any other legally permissible purpose. The undersigned hereby consents to the collection, use, and disclosure by the Company of his or her personal information contained in (or included with) this form for the foregoing purposes.

Physician or Physician's Assistant/Nurse (Family Name/Last Name, Given Name/First Name) (Please PRINT clearly.)	Date of Examination (dd/mm/yyyy)
Physician Signature X	Date (dd/mm/yyyy)
Physician's Assistant/Nurse Signature X	Date (dd/mm/yyyy)

PART 3. CURRENT VITALS. COMPLETE FOR PARAMEDICALS AND MEDICALS. MUST BE COMPLETED BY THE NURSE OR THE EXAMINING PHYSICIAN (i.e., Cardiologist, Internist, or General Practitioner)

Family Name/Last Name of Person Examined	Given Name/First Name of Person Examined	Date of Birth (dd/mm/yyyy)

A. Height _____m _____cm Weight _____kg BMI _____

Did Proposed Insured's weight change over the past 12 months? ☐ Yes ☐ No

If "Yes," please provide details: _____

Loss of _____ Gain of _____ kilograms

B. Pulse _____ per minute Regular ☐ Yes ☐ No

If irregular, type of irregularity: _____

If extra systoles, please state number per minute: _____

C. Blood pressure (seated)_____ / _____ 2nd_____ / _____

D. Urinalysis (Complete only if age 18 or older. Please fill in blanks or attach results and forward with this form)

Protein_____ Sugar_____ Blood_____

Date of last menses_____

For Paramedicals only: Skip to Part 6.

PART 4. CURRENT HEALTH STATUS. COMPLETE FOR MEDICALS ONLY. MUST BE COMPLETED BY THE EXAMINING PHYSICIAN (i.e., Cardiologist, Internist, or General Practitioner)

A. Is there any abnormality:

1. Of the oral cavity, eyes, ears, nose, throat, skin (including xanthelasma, xanthomata, arcus senilis)? ☐ Yes ☐ No

2. Of the lymph nodes or the thyroid gland? ☐ Yes ☐ No

3. Of chest, spine or extremities? ☐ Yes ☐ No

4. Of lungs on percussion and auscultation? ☐ Yes ☐ No

Please circle each condition where there is a positive response and report the details of such conditions on page 9.

B. Are any murmurs present? ☐ Yes ☐ No

If "Yes," complete the following:

Describe below the location of transmission, if any, and your diagnostic impression:

1. Location: ☐ apex ☐ base ☐ intercostal space ☐ right of sternum ☐ left of sternum

Intensity: ☐ Gr I ☐ Gr II ☐ Gr III ☐ Gr IV ☐ Gr V ☐ Gr VI

Timing: _____systolic _____diastolic

Classification: _____organic _____physiologic

2. Complete if more than one murmur:

Location: ☐ apex ☐ base ☐ intercostal space ☐ right of sternum ☐ left of sternum

Intensity: ☐ Gr I ☐ Gr II ☐ Gr III ☐ Gr IV ☐ Gr V ☐ Gr VI

Timing: _____systolic _____diastolic

Classification: _____organic _____physiologic

C. Is there:

1. Intra-abdominal abnormality? ☐ Yes ☐ No

2. Any surgical scars? ☐ Yes ☐ No

3. A hernia? If "Yes," describe: _____ ☐ Yes ☐ No

4. Abnormality of the central nervous system (muscular power, reflexes, etc.)? ☐ Yes ☐ No

5. Oedema of the ankles? ☐ Yes ☐ No

6. Inequality or inadequacy of the pulsations of the femoral, dorsalis pedis or posterior tibial arteries? ☐ Yes ☐ No

For "Yes" answers, please provide details on page 9.

PART 4. CURRENT HEALTH STATUS (continued)

Question number	Details

PART 5. MATURE AGE QUESTIONNAIRE

PLEASE NOTE **To be completed for all Clients age 71 and over. Must be completed by the examining physician in conjunction with the Confidential Medical Questionnaire.**

Please introduce this part of the exam as an assessment of mobility, daily living activities and memory.

1. Please indicate physical activity level (check all applicable)

- ☐ No mobility or gait limitations
- ☐ Uses aids, if checked, specify type: _____ (ie: walking stick, cane, walker, wheelchair, or other)
- ☐ Fall history in last 5 years, if checked, please specify number _____ and details.

Please provide details:

2. Does the Proposed Insured have any evidence of cognitive disorder such as dementia, memory loss, confusion, behavioral change, lack of comprehension, etc.? ☐ Yes ☐ No

If "Yes," please provide details:

3. Does the Proposed Insured need assistance with any activities of daily living including feeding, bathing, dressing, toileting, grooming and mouth care, transferring bed/chair, climbing stairs? ☐ Yes ☐ No

If "Yes," please provide details:

4. Please record how long it takes the Proposed insured to complete the following task.

Get up from a seated position, walk 10 feet, return and sit again.

_____ seconds

Comments:

5. In the space below, ask the proposed insured to:

Draw a circle

Mark in all the numbers to indicate the hours of a clock

Mark hands of clock to show 10 minutes past 9 o'clock (9:10)

Signature of Interviewer	Date (dd/mm/yyyy)
X	

PART 6. EXAMINER INFORMATION

Did you act as a translator or did you require a third party translator to question the person examined? ☐ Yes ☐ No
If "Yes," complete and attach an Interpreter Services Declaration form.

By signing below, the undersigned acknowledges the Company will collect, use, and may disclose personal information to process and evaluate an application, transaction, request, or administer coverage in connection with, life insurance, annuity, investment account, or other product or service the Company may offer or issue to a client, or for any other legally permissible purpose. The undersigned hereby consents to the collection, use, and disclosure by the Company of his or her personal information contained in (or included with) this form for the foregoing purposes.

Family Name/Last Name of Examiner	Given Name/First Name of Examiner
Please state your Internal Medicine and/or Cardiology Certification(s)	
Number(s)	Country(ies)
Other Certifications and Countries Obtained	
Current Specialty of Practice	
Examiner's Signature X	Date (dd/mm/yyyy)
Address of Examiner's place of practice	

Was the examination completed at the examiner's normal place of practice and in a medical examination room? ☐ Yes ☐ No

If "No," please describe the setting: