Mature Age Questionnaire

INSTRUCTIONS TO PHYSICIAN

- Complete this questionnaire if the Proposed Insured is age 71 years and over
- If any party to this examination has a personal or professional relationship with the Proposed Insured, please do not proceed
- Please answer every question and complete this questionnaire in English
- Obtain and submit a certified true copy of the Proposed Insured's **identity document** presented during this examination. If you are not satisfied with the Proposed Insured's identity, or he or she is unable to provide satisfactory identification, please do not proceed with the examination
- A Physician (Cardiologist, Internist, or General Practitioner) must complete this questionnaire with the Proposed Insured
- If the Proposed Insured requires assistance from an interpreter, please have the Interpreter Services Declaration completed by both the Proposed Insured and the Interpreter

Please inform the Proposed Insured that this questionnaire is an assessment of their mobility, daily living activities and memory.

1	Please tick all applicable boxes to indicate the Proposed Insured's physical activity level ☐ No mobility or gait limitations ☐ Uses Aids – please provide type (walking stick, cane, walker, wheelchair, other) ☐ Fall history in the past 5 years – please provide details (number of falls, dates, any injury)	
2	Is there any evidence of cognitive disorder such as dementia, memory loss, confusion, behavioral change, lack of comprehension, etc.? If "Yes," please provide details	☐ Yes ☐ No
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? If "Yes," please provide details	☐ Yes ☐ No
4	Please record the time it takes for the Proposed Insured to get up from a seated position, walk 3 meters, return and sit again seconds Please provide comments	
5	In the space below, please ask the Proposed Insured to: ▪ Draw a circle ▪ Mark in all the numbers to indicate the hours of a clock ▪ Mark hands on the clock to show 10 minutes past 9 o'clock (9:10)	

CONSENT AND AUTHORISATION

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.

Signature of Proposed Insured	
Name of Proposed Insured	
ID / Passport Number of Proposed Insured	Date (dd/mm/yyyy)

EXAMINER INFORMATION AND SIGNATURE

Did you complete the questionnaire at your normal place of practice and in a medical examination room? If "No," where was the questionnaire completed?	☐ Yes ☐ No
Did you or a third party act as an interpreter for the Proposed Insured? If "Yes," please provide an Interpreter Services Declaration form.	☐ Yes ☐ No

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's Signature	Date (dd/mm/yyyy)
Surname / Family Name / Last Name	
Given Name / First Name	
Current Specialty	Medical License Number
Practice Address	