John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Medical Exam

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured.
Notice of Disclosure of Information form NB5006 must be used with this Medical Exam if it is being submitted on its own without the main application.
Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

PROPOSED LIFE INSURED

1. a) Name _____ (First / Middle / Last) b) Date of Birth ____ ____ ____ (month / day / year)

   c) Social Security/Tax ID Number _____ d) Sex ☐ Male ☐ Female

SMOKING STATUS

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?

   ☐ Yes ☐ No If 'Yes', provide details below.

Product:		Frequency:	Current	Past	Date Last Used (month day year)
Cigarettes	____	pack(s)/day	☐	☐	
Cigars	____	x /day	☐	☐	
Other: _____	____	x /day	☐	☐	

FAMILY QUESTIONS

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes ☐ No

4. Please provide the following details.

	Family History	Age	Give Details of Present State of Health
LIVING	Father		
	Mother		
	Brothers & Sisters		

	Family History	Age	Cause of Death
DECEASED	Father		
	Mother		
	Brothers & Sisters		

5. a) Name and Address of Personal or Attending Physician

First / Middle / Last

Street No. & Name / Suite No. / City / State / Zip code

b) Telephone No. _____

c) Date last consulted (month day year) | Reason for consultation | Diagnosis/Result of visit

d) List any medications (prescription or nonprescription) you are taking currently

HEALTH QUESTIONS

Please complete Details for 'Yes' answers on page 3.

6. **Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have:**
   a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No
   b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease? ☐ Yes ☐ No
   c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? ☐ Yes ☐ No
   d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis? ☐ Yes ☐ No
   e) Any nervous, mental or emotional disorder, or received counseling for anxiety, depression, stress, or any other emotional condition? ☐ Yes ☐ No
   f) Alzheimer's disease, dementia, memory loss or organic brain syndrome? ☐ Yes ☐ No
   g) Multiple sclerosis (MS), muscular dystrophy, ALS (Lou Gehrig's disease), Parkinson's disease or tremors? ☐ Yes ☐ No
   h) Injuries due to falls or imbalance? ☐ Yes ☐ No
   i) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, fractures, or any other bone, joint or muscle disorder? ☐ Yes ☐ No
   j) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? ☐ Yes ☐ No
   k) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines? ☐ Yes ☐ No
   l) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? ☐ Yes ☐ No
   m) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? ☐ Yes ☐ No
   n) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine? ☐ Yes ☐ No
   o) Cancer, leukemia, lymphoma, malignant melanoma or tumors of any kind, malignant or benign? ☐ Yes ☐ No
   p) Any other health impairment or medically treated condition? ☐ Yes ☐ No

7. **Within the last 10 years have you had:**
   a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? ☐ Yes ☐ No
   b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), except for HIV or AIDS, whether conducted on an in-patient or out-patient basis? ☐ Yes ☐ No

8. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

9. Do you:
   a) have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing (except for HIV or AIDS) or investigation recommended by a physician which has not yet been completed? ☐ Yes ☐ No
   b) consume alcoholic beverages? ☐ Never ☐ Currently ☐ In the past

   Complete if **Currently** was selected in 9 b)

Type of beverage	Frequency	Quantity

   Complete if **In the past** was selected in 9 b)

   Date Stopped (month / year) _____

   Reason Stopped _____

10. **Within the last 10 years have you:**
    a) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counseling or participated in a support group? ☐ Yes ☐ No
    b) used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? ☐ Yes ☐ No
    c) used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions? ☐ Yes ☐ No

HEALTH QUESTIONS continued

Details for Yes answers to Health Questions. If more space is required, use the Medical Questions Continuation Sheet, NB5034US.

Question No.	Date month day year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

1. The Company to obtain an investigative consumer report on me.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, the MIB, Inc., or any other similar person or organization to give The Company and its reinsurers information about me or any minor child who is to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

I further authorize The Company to disclose such information and any information developed during its evaluation of this application to: (a) its reinsurers; (b) the MIB, Inc.; (c) other insurance companies as designated by me; (d) me; (e) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (f) any medical professional designated by me; or (g) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB, Inc.

This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

SIGNATURES

If the Proposed Life Insured is under age 15, Parent or Guardian must sign and include relationship.

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief.
I hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at City State This Day of Year

Signature of Examiner as Witness

X

Signature of Proposed Life Insured (Parent or Guardian, if under age 15)

X

Print Name of Examiner

Name of Agent (Please print)

Agent's Code

John Hancock
the future is yours

Examiner's Report

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Print and use black ink.

PROPOSED LIFE INSURED

1. a) Name _____ (First / Middle / Last) b) Date of Birth ____ ____ ____ (month / day / year)

SECTION 1

Complete for all paramedicals and medical examinations.

2. a) Height _____
   Did you measure? ☐ Yes ☐ No
   b) Weight _____
   Did you weigh? ☐ Yes ☐ No
   c) Any weight change in the past 12 months? ☐ Yes ☐ No
   If 'Yes', amount _____ ☐ Loss ☐ Gain
   Reason _____

3. Blood Pressure Readings

	1.	2.	3.
Systolic			
Diastolic			

4. Pulse ☐ Regular ☐ Irregular
   _____
   Type of irregularity _____
   If extra systoles, No. per min. _____

5. Describe general appearance _____

6. Did anyone accompany the Proposed Life Insured during the examination? ☐ Yes ☐ No
   If 'Yes', please provide details
   Name of the person who came _____ Relationship to Proposed Life Insured _____
   Why present _____

7. Did the Proposed Life Insured understand and answer all the questions asked in connection with this exam? ☐ Yes ☐ No
   If 'No', please provide details _____

8. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? ☐ Yes ☐ No
   If 'Yes', please provide details _____

SECTION 2

Complete only for medical examinations.

9. On examination is/are there any:
   a) Extra or abnormal heart sounds? ☐ Yes ☐ No
   b) Murmurs? ☐ Yes ☐ No
   c) Cardiomegaly or cardiac enlargement? ☐ Yes ☐ No
   d) Inadequate circulation anywhere? ☐ Yes ☐ No
   (e.g. shortness of breath, edema, stasis dermatitis, PVD)
   If 'Yes', provide details below.

Please complete the following heart chart if there are any YES answers to question 9, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or if there is a history of hypertension or heart disease.

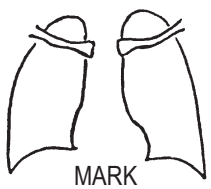
Murmur If more than one, describe in Details below.

☐ None ☐ Systolic ☐ Diastolic | Grade I II III IV V VI | ☐ Loud ☐ Harsh ☐ Rough ☐ Soft ☐ Blowing

Signs of Failure

Shortness of breath?	☐ Yes	☐ No
Cyanosis?	☐ Yes	☐ No
Engorgement of neck veins?	☐ Yes	☐ No
Swelling of ankles?	☐ Yes	☐ No
Rales at lung bases?	☐ Yes	☐ No

Location
Area of Murmur by XXXX
Transmission by .....→



SECTION 2 continued

Complete Details below for Yes answers to questions 10-11.

10. On examination, is there any abnormality of:
    a) Respiratory system? ☐ Yes ☐ No
    b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)? ☐ Yes ☐ No
    c) Eyes, ears, nose, mouth, pharynx, head and neck (incl. hearing, vision, optic fundi, speech)? ☐ Yes ☐ No
    d) Skin, lymph nodes, peripheral arteries or veins? ☐ Yes ☐ No
    e) Nervous system (incl. reflexes, weakness, gait, paralysis, tremors)? ☐ Yes ☐ No
    f) Genitourinary system (incl. prostate, rectum (only if male), external genitalia, breasts)? ☐ Yes ☐ No
    g) Endocrine systems (including thyroid)? ☐ Yes ☐ No
    h) Musculoskeletal system (incl. spine, joints, amputation, deformity)? ☐ Yes ☐ No

11. Have you examined the Proposed Life Insured in the past year? ☐ Yes ☐ No
    Is the Proposed Life Insured your private patient? ☐ Yes ☐ No
    If 'Yes', please provide details of any medical history which is pertinent to the mortality risk and not already disclosed. _____

Details for Yes answers to questions 10 - 11. If more space is required, use the Medical Questions Continuation Sheet, NB5034US.

Question No.	Date month day year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

EXAMINER'S CERTIFICATION AND SIGNATURE

How did you identify the Proposed Life Insured? ☐ Driver's License (with photo) ☐ Other photo ID _____

Examination location ☐ Examiner's Office ☐ Proposed Life Insured's home ☐ Proposed Life Insured's place of business

Indicate requirements completed ☐ Blood ☐ Urine ☐ EKG ☐ TST

Ticket number _____ Date sent to lab _____ (month day year) Date sent to home office _____ (month day year)

Indicate any requirements not completed and reason

I hereby certify that I have personally examined the Proposed Life Insured and have correctly and fully reported my findings.

Signed at City _____ State _____ This _____ Day of _____ Year _____

Name of Examiner _____ ☐ MD ☐ RN ☐ DO ☐ RPN/LPN

Signature of Examiner X _____

Company
☐ APPS ☐ EMSI ☐ Exam One ☐ Portamedic
☐ Superior Mobile Medics ☐ Other _____

Examination completed on (date and time) _____ (month day year) _____ Time

City, State _____ Telephone No. _____