

## **PACIFIC LIFE INSURANCE COMPANY**

Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (866) 964-4860  
www.PacificLife.com



## **MED PLUS**

For Proposed Insured Age 71 & above

---

### **EXAMINER INSTRUCTIONS**

1. Prior to arriving at the examination site, separate the words on the last page by cutting along the dotted lines to make flashcards for the Delayed Word Recall exercise.
2. The examination must be conducted in privacy. A spouse, relative or any other persons should not be present during the completion of the Med Plus exam.
3. Speak clearly, calmly and in a tone loud enough to be heard.
4. Allow enough time for the proposed insured to answer the questions, roughly 1-2 minutes.
5. If the proposed insured refuses to answer a question, record the answer as "Refused to Answer" and proceed to the next question.
6. If you need any clarification on how to complete the Med Plus exam, please contact Pacific Life Insurance Company's Risk Selection (underwriting) Department.

---

### **LIFESTYLE, MEDICAL & ASSISTANCE INSTRUCTIONS**

1. Advise the proposed insured that, they may have already given some of this information at the time of the application. This will serve as confirmation.
2. Advise the proposed insured to let you know if anything asked is unclear or if they have any questions.

---

### **DELAYED WORD RECALL INSTRUCTIONS**

#### **For Part I**

1. Advise the proposed insured that they are NOT allowed to write down the words.
2. Show the proposed insured each word on the flashcards and read each word out loud.
3. Ask the proposed insured to repeat the word and form a sentence using the word.
4. Wait for his/her reply.
5. Proceed to next word and repeat process with all words.
6. Do not record their responses at this time. The proposed insured's response will be recorded in Part II.
7. Record the time when the Delayed Word Recall Part I is completed in the space provided.
8. Place the cards out of sight.
9. Part II of the Delayed Word Recall must begin between 5 and 6 minutes from the end of Part I. Please ensure that no more or less than 5 or 6 minutes passes between the end of Part I and the start of Part II.

#### **For Part II**

1. Ask the proposed insured to recall as many words as they can remember.
2. Write down the words that they recall in the space provided.
3. Record the time when the Delayed Word Recall Part II is completed in the space provided.

---

### **MOBILITY ASSESSMENT INSTRUCTIONS**

1. When conducting the mobility assessment a straight back armless chair is preferred.
2. Ask the proposed insured to rise from his/her chair and walk 10 feet, turn around, walk back to the chair, and sit back down.
3. Time how long it takes the proposed insured to perform the above task and record the time below.
4. Observe the proposed insured's mobility and then record the answers, including details of any difficulties in the Mobility Assessment section.

**PACIFIC LIFE INSURANCE COMPANY**

Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (866) 964-4860  
www.PacificLife.com

**PACIFIC LIFE****MED PLUS**

For Proposed Insured Age 71 &amp; above

Proposed Insured's Name: First	MI	Last	Date of Birth (mm/dd/yyyy)
--------------------------------	----	------	----------------------------

**DELAYED WORD RECALL – Part I**

Show the proposed insured each word on the flashcards and read each word out loud. Ask the proposed insured to repeat the word and form a sentence using the word. Wait for his/her reply. Repeat this process with all of the words. At the completion of the 10 words record the time below.

Current Time: \_\_\_\_\_ ☐ AM ☐ PM

**LIFESTYLE QUESTIONS** (Provide details to any Yes answers in the space provided.)

- How long have you lived in your residence? \_\_\_\_\_
- Do you live with another person? ☐ No ☐ Yes, what is their relationship to you? \_\_\_\_\_
- Do you have family in the area?
  - ☐ Yes, what is their relationship to you? \_\_\_\_\_
  - ☐ No, who would take care of you in the event of an emergency or illness? \_\_\_\_\_
- Do you engage in any type of exercise?
  - ☐ No
  - ☐ Yes, What kind \_\_\_\_\_ Where \_\_\_\_\_ Frequency \_\_\_\_\_
- Do you participate in any of the following activities outside the home? ☐ No ☐ Yes: (check all that apply)
  
☐ Employment ☐ Volunteering ☐ Attending place of worship ☐ Hobbies ☐ Other Outside Activities
  
If yes, provide details \_\_\_\_\_ and number of hours per week \_\_\_\_\_
- When did you last drive an automobile? \_\_\_\_\_ If no longer driving, why did you stop? \_\_\_\_\_

**MEDICAL AND ASSISTANCE QUESTIONS** (Provide details to any Yes answers below.)

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession for any disorder of the brain including Alzheimer's disease, dementia, organic brain syndrome, amnesia, confusion, memory loss or behavioral changes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession for loss of balance or falls?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever used a multi-prong cane, walker, wheelchair, motorized scooter, or stair/chair lift?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had any impairment, whether mental or physical, for which you have needed or required assistance or supervision with performing the following activities: (check all that apply)  |                          |                          |
| <input type="checkbox"/> toileting <input type="checkbox"/> bathing <input type="checkbox"/> dressing <input type="checkbox"/> eating <input type="checkbox"/> transferring or ambulating  |                          |                          |
| <input type="checkbox"/> controlling your bowel or bladder <input type="checkbox"/> housekeeping <input type="checkbox"/> meal preparation <input type="checkbox"/> laundry <input type="checkbox"/> shopping  |                          |                          |
| <input type="checkbox"/> telephone use <input type="checkbox"/> managing your finances <input type="checkbox"/> managing and/or taking your medication   |                          |                          |

**DETAILS OF YES ANSWERS** (Identify question number. If more space is needed use an additional sheet and check here. ☐)


**MOBILITY ASSESSMENT**

EXAMINER INSTRUCTIONS: (A STRAIGHT BACK ARMLESS CHAIR IS PREFERRED)

- Ask the proposed insured to rise from his/her chair and walk 10 feet, turn around, walk back to the chair, and sit back down.
- Time how long it takes the proposed insured to perform the above task and record the time below.
- Observe the proposed insured's mobility and then record the answers below, including details of any difficulties.

1. Rising from chair: <input type="checkbox"/> Rises easily with no assistance <input type="checkbox"/> Requires more than one attempt <input type="checkbox"/> Has trouble with balance, needs assistance, or has significant difficulty  2. Walking: <input type="checkbox"/> Unassisted at a normal pace <input type="checkbox"/> With assistance or mild difficulty <input type="checkbox"/> Stumbles, extremely slow pace, needs substantial assistance	3. Turning: <input type="checkbox"/> Smoothly with no hesitation <input type="checkbox"/> Needs mild assistance or has mild difficulty <input type="checkbox"/> Stumbles or needs support  4. Sitting down in chair: <input type="checkbox"/> Smoothly with no hesitation <input type="checkbox"/> Drops suddenly into chair or if chair has armrests used them for support <input type="checkbox"/> Needs assistance
--	---

Comments

Time: \_\_\_\_\_

**DELAYED WORD RECALL – Part II**

Tell the proposed insured "A few minutes ago I read you some words and asked you to make a sentence with each of them. I would like you to tell me as many of the words you remember." Record the response below including any repetitions or incorrect words:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Time: \_\_\_\_\_ ☐ AM ☐ PM

**EXAM INFORMATION**

- Examined at:  
☐ My office ☐ Other: \_\_\_\_\_
- Date of Exam (mm/dd/yyyy): \_\_\_\_\_
- Time of Exam: \_\_\_\_\_ ☐ AM ☐ PM
- Name of Producer Requesting Exam: \_\_\_\_\_

**MEDICAL EXAMINER'S INFORMATION**

Name: First	MI	Last	Soc. Sec. # / TIN
Address: Street	City	State	Zip Code
Signatures			

SIGNED AND DATED ON: 

Date (mm/dd/yyyy)

**X**

Examiner's Name: First MI Last (print)

Examiner's Signature

## DELAYED WORD RECALL FLASHCARDS

EXAMINER INSTRUCTIONS: Prior to arriving at the examination site, separate the following word flashcards by cutting along the designated lines. These flashcards will be used to complete the Delayed Word Recall exercise. Once Part I of the Delayed Word Recall exercise is completed, place the set of flashcards in your case and out of sight for the remainder of the exam.

**DESK**

**FLOWER**

**BIRD**

**SHOE**

**STOVE**

**MOUNTAIN**

**GLASSES**

**CLOUD**

**BOAT**

**PENCIL**