



**West Coast Life
Insurance Company**
A PROTECTIVE COMPANY

ACTIVITIES QUESTIONNAIRE

(Required for all Proposed Insureds Over Age 70, to be administered by an examiner)

1. PROPOSED INSURED'S NAME (<i>Please Print</i>)	Date of Birth
2. DO YOU PARTICIPATE IN ANY TYPE OF WORK ACTIVITIES (Full-Time, Part-Time, Volunteer, Etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____ Frequency: _____	
3. ARE YOU A MEMBER OF ANY TYPE OF CLUB OR ORGANIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Activities Involved: _____ Frequency of Attendance: _____	
4. DO YOU CURRENTLY DRIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Describe any violations or accidents within the past five years: _____ _____ (If "No", complete the following) When did you last drive? _____ Why did you stop driving? _____	
5. DO YOU PARTICIPATE IN ANY TYPE OF EXERCISE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____ Frequency: _____	
6. DO YOU PARTICIPATE IN ANY OTHER HOBBIES OR ACTIVITIES? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____ Frequency: _____	
7. DO YOU LIVE ALONE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", give full details) _____	
8. DO YOU HAVE A PET? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____	
9. DO YOU PERFORM REGULAR HOUSEHOLD TASKS (e.g., cooking, cleaning, laundry, shopping, yard or handy work)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Which ones? _____	
10. DO YOU HAVE ANYONE THAT HELPS YOU WITH OR DOES REGULAR HOUSEHOLD TASKS FOR YOU (e.g. Hired Help, Friend, Family)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give full details) _____	
11. DO YOU MANAGE YOUR OWN FINANCES? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", give full details) _____	
12. DO YOU TAKE ANY TYPE OF MEDICATIONS (e.g., prescription, over-the-counter, vitamins, herbs, or supplements)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____ Frequency: _____	
13. HAVE YOU FALLEN OR HAD ANY INJURIES IN THE PAST FIVE YEARS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give full details) _____	
14. HAVE YOU USED ANY WALKING ASSISTANCE IN THE PAST FIVE YEARS (e.g., crutches, cane, leg braces, walker, wheelchair, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete the following) Type: _____ Frequency: _____ Date Last Use: _____	
15. ADDITIONAL DETAILS AND COMMENTS	
I agree all statements and answers to the above questions are complete and true.	

DATED AT _____ (City) _____ (State)	ON _____ (Month) _____ (Day) _____ (Year)
WITNESS	PROPOSED INSURED