Medical Examination

The Proposed Insured should complete Part One, Sections A to D of this form. The Medical Examiner should complete Parts Two and Three.
The Proposed Insured must sign in the Medical Examiner's presence.

Part One: TO BE COMPLETED BY THE PROPOSED INSURED

Section A: Personal Details

1	Full name of Proposed Insured	
2	Date of birth	
3	Age	
4	Name and address of your personal physician? If none, so state.	

Section B: Medical History

Date and reason last consulted?	
What treatment was given or medication prescribed?	

Please answer the following questions carefully, circling applicable items in each list if they are relevant to you and then ticking the 'Yes' box. You will need to provide more information for any instance where you answer 'Yes'. Please use continuation sheets to give further details and ensure that it is clear to which question your information relates. You should include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

	5 Have you ever been treated for or ever had any known indication of:	Yes	No
a)	Disorder of eyes, ears, nose or throat?		
b)	Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; psychiatric or nervous disorder?		
c)	Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?		
d)	Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?		
e)	Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?		
f)	Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?		
g)	Diabetes; thyroid or other endrocrine disorders?		
h)	Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?		
I)	Deformity, lameness or amputation?		
j)	AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any immunological disorder?		
k))	Allergies, anaemia or other disorder or the blood?		

	Yes	No
6 Do you smoke? If so, what is your average daily consumption?	☐	☐
7 Do you drink alcoholic beverages? If so, what is your average daily consumption?	☐	☐
8 In the past 5 years, have you used:		
a) barbiturates, sedatives or tranquilisers habitually?	☐	☐
b) LSD, marijuana, cocaine or any amphetamine?	☐	☐
c) heroin, morphine or any other narcotic drug?	☐	☐
9 Have you within the past 5 years been diagnosed with cancer of the nodes (glands), experienced enlargement of the lymph nodes, diarrhoea, unusual skin lesions, unexpected infections or had a blood transfusion?	☐	☐
10 In the past 10 years, have you been treated for alcoholism or any drug habit?	☐	☐
11 Are you now under observation or taking treatment?	☐	☐
12 Have you had any change in weight in the past year?	☐	☐
13 Other than above, have you within the past 5 years:	☐	☐
a) Had any psychiatric or physical disorder not listed above?	☐	☐
b) Had a checkup, consultation, illness, injury or surgery?	☐	☐
c) Been a patient in a hospital, clinic, sanatorium or other medical facilty?	☐	☐
d) Had an electrocardiogram, X-ray or other diagnostic test?	☐	☐
e) Been advised to have any diagnostic test, hospitalisation or surgery which was not completed?	☐	☐
14 Have any of your immediate family (including spouse) ever been treated for: tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, psychiatric illness or AIDS?	☐	☐
15 To be answered by females only		
a) Have you ever had any disorder of menstruation, pregnancy or of the female organs or breast?	☐	☐
b) To the best of your knowledge and belief are you now pregnant?	☐	☐

Section C: Family History

Family History

	Age	Living State of Health	Age of Death	Dead Cause of death
Father				
Mother				
Brothers				
Sisters				
Wife				
Husband				

Section D: Declaration by Proposed Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Dated this _____ day of _____ 20 _____

Signature of Medical Examiner

Signature of Proposed Insured (or Applicant if Proposed Insured is under 15)

I hereby authorise any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organisation, institution or person, that has any records or knowledge regarding myself or my health to give Unilife any such information. A photographic copy of this authorisation shall be as valid as the orginal.

Date _____ Signature _____

Note: The Proposed Insured must sign in the Examiner's presence.

Part Two: MEDICAL EXAMINER'S REPORT (TO BE COMPLETED IN PRIVATE)

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting.
Please print name and address. Examinations must be made in private.

Please make a careful examination of the heart and lungs using a stethoscope against bare skin. Please bear in mind that, with some histories, findings may have particular significance, thus comments regarding relevant findings should be included in the space provided for details below.

Name of agent _____

Please tick appropriate units

☐ m ☐ ft ☐ cm ☐ in ☐ kg ☐ lbs

1 Height _____ m/ft _____ cm/in Weight _____ kg/lbs Did you take these measurements? ☐ Yes ☐ No

2 Measurement on bared skin

Chest _____ cm/in Inspiration and expiration _____ cm/in Abdomen _____ cm/in

3

	At Rest	After exercise	3 minutes later
Pulse rate			
Irregularities per min.			

4 Blood Pressure: Please record all readings. With history of hypertension or if first reading is over 135 systolic or over 85 disastolic, take two additional readings at intervals.

	First reading	Subsequent Readings	
Systolic			
Diastolic			

Is Diastolic at: Disappearance of all sounds (Phase V)? or Change of Sound (Phase IV?)

5 Heart: Identify whether there is the presence of any of the following. Please provide further details of all 'Yes' answers using continuation sheet(s), ensuring that it is clear to which question your information relates.

	Yes	No		Yes	No
Enlargement			Dyspnea		
Murmur			Edema		

Please describe, separately if necessary

Location

	Yes	No		Yes	No
Constant			Inconstant		
Transmitted			Localised		
Systolic			Presystolic		
Diastolic			Soft (Gr 1-2)		
Mod (Gr 3-4)			Loud (Gr 5-6)		

After Exercise

Increased			Absent		
Unchanged			Decreased		

6 Is there on examination any abnormality of the following: (Circle applicable items and give details)

	Yes	No
a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction)		
b) Skin (including scars); lymph nodes; varicose veins or peripheral arteries		
c) Nervous system (include reflexes, gait, paralysis)		
d) Respiratory system		

	Yes	No
e) Abdomen (include scars)	☐	☐
f) Genitourinary system (include prostate)	☐	☐
g) Endocrine system (include thyroid and breast)	☐	☐
h) Musculoskeletal system (include spine, joints, amputations, deformities)	☐	☐
7 Are there any hernias?	☐	☐
Are there any hemorrhoids?	☐	☐

8 Urinalysis: ☐ Specific Gravity ☐ Albumin ☐ Sugar ☐ Blood ☐ Urobilinogen

Are you sending a portion of the specimen to the Company's authorised laboratory for microscopic analysis? ☐ Yes ☐ No

Send specimen to Laboratory if: (1) the applicant is over 60; (2) you detect albumin or sugar or suspect recent disease of the urinary tract; (3) there is pronounced obesity, diabetes in the family or elevated blood pressure; or (4) advised by the agent.

Part Three: STATEMENT OF MEDICAL EXAMINER

1 Are you in any way related to the Proposed Insured or agents? ☐ Yes ☐ No

If so, to whom, and how are you related?

2 Are you aware of anything about the health, habits, environment or mode of life which might unfavourably affect the insurability of Proposed Insured? ☐ Yes ☐ No

If 'Yes', please give details

(A confidential report may be sent to the Medical Director)

3 How long and how well have you known Proposed Insured?

4 Do you consider the risk of the Life assessed to be average, under average, doubtful or bad?

If other than average, kindly give reasons

5 I have examined

this day of 20 at am/pm

Examination was made in private at ☐ my office ☐ residence of Proposed Insured

☐ place of business of Proposed Insured

Examination was a ☐ complete medical ☐ short medical ☐ para medical

Signature of Examiner

After completing the above, please print the following using block letters (a rubber stamp or typewriter will suffice)

Name

Address

Telephone

Email

Note for the applicant: This form constitutes part of your application. If you require any further details, please ask your financial adviser. Alternatively you can contact your nearest Unilife office, details of which are available via our website, or get in touch using our email address: info@ses-zambia.com