Private Medical Attendant's Report
Strictly Private and Confidential

Proposal number(s)/Policy number(s)

To be completed by the Intermediary/Life Insured

Particulars of Intermediary

First Name(s)

Last Name

Intermediary's code

Particulars of Life Insured

First Name(s)

Last Name

Identity No./Passport No.

Date of birth

Address

Signature of Life Insured

To be completed by the Medical Examiner

Important: The Proposer/Life Insured has requested that you provide us with (and has authorised us to obtain) this information from you. The Proposer/Life Insured in addition has authorised us to share this information with other life offices, either directly or through the Life Office Association (LOA). This will be done for the purposes of underwriting and/or claims assessment. Under the terms of the LOA protocol the proposer/life insured may enquire about information held by the LOA. Such information will be made available to him/her by his/her nominated medical practitioner.

Particulars of Medical Examiner

First Name(s)

Last Name

Qualifications

Telephone number

Email

Date of procedure/examination/questionnaire

Are you the Life Insured's usual medical practitioner? ☐ Yes ☐ No

I confirm that this examination has been conducted in my surgery by myself and that photographic identity was supplied according to the LOA protocol. ☐ Yes ☐ No

Signature of Examiner

Compensation Payable *(State full name of practice or partnership)*

First Name(s)

Last Name

Address

Practice code

VAT Registration number

Tariff code ☐ General practitioner Fee payable

☐ Specialist physician Fee payable

Medical Report

We have received a Proposal for Life Insurance from the person as indicated on the front page. To be able to consider such a proposal for insurance, this medical report is required. We kindly request that you complete this report for us.

1. a) How long have you been the patient's usual Medical Attendant?

b) How far do the records you hold go back?

c) When was medical advice last sought and why?

2. Is any treatment by drugs or otherwise being administered at present? ☐ Yes ☐ No If 'Yes', please give details below.

3. Do you consider that the patient is currently in good health?

4. Please indicate any height/weight details you may have recorded.

Date *(dd/mm/yyyy)*	**Height**	**Weight**

5. Please give details of any blood pressure readings. You should indicate whether the patient is receiving treatment for hypertension at the date of reading by deleting Yes or No as applicable.

Date *(dd/mm/yyyy)*	**Systolic**	**Diastolic**	**Treatment**	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

6. Please give particulars of illnesses or accidents which have required treatment or advice from yourself or other medical advisers or centres.

Date *(dd/mm/yyyy)*	**Nature of Condition**	**Treatment**	**Duration**	**Time off work**	**Was Recovery Complete?**

7. Has any of the above left any sequelae? Yes No If 'Yes', please give details below.

8. Please give details of any urine test, X-Rays, ECGs, blood tests or other investigations (provide copies of any reports if possible)

Nature of investigation

Result (continue on a separate sheet if necessary)

9. Please tell us about any family history prior to the age of 65. This includes heart disease, stroke, diabetes, cancer, multiple sclerosis and Alzheimer's disease or any familial condition in parents or siblings.

10. Please provide information regarding:

Consumption of alcohol:

Smoking habits:

Misuse of drugs:

If you have any additional information which is relevant, or if there is insufficient space to complete any of the above questions, please continue here and/or on a separate sheet of paper.

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