

# PARAMEDICAL EXAMINATION

## IMPORTANT INFORMATION

**WARNING : PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT CAP.142, YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY ISSUED MAY BE VOID.**

Please complete in ENGLISH and BLOCK CAPITALS.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

Capitalised terms in this form have the same meaning as defined in the Policy.

### PART 1

Select the box that applies

#### (To be completed by the patient )

Name			
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy)
ID Type		ID Number	
Please provide the following details :			
a) Name and Address of Personal or Attending Physician			
b) Phone Number			
c) Date last consulted	(dd/mm/yyyy)		
Reason for consultation			
Diagnosis/Result of visit			
d) List any medications (prescription or non-prescription) you are taking currently			

**Smoking Status**

1. 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
Cigarettes	pack(s) day	<input type="checkbox"/>	<input type="checkbox"/>	(dd/mm/yyyy)
Cigars	/day	<input type="checkbox"/>	<input type="checkbox"/>	(dd/mm/yyyy)
Other	/day	<input type="checkbox"/>	<input type="checkbox"/>	(dd/mm/yyyy)

**Family Questions**

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

3. Please provide the following details:  Yes  No

Living			Deceased		
	Age	Present Health		Age	Cause of Death
Father			Father		
Mother			Mother		
Siblings			Siblings		

**Health Questions**

Please provide details for 'Yes' answers in the "Supplementary Information" section below.

4. **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 counselling 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, Parkinson's disease or tremors?  Yes  No
- h) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, or any other bone, joint or muscle disorder?  Yes  No
- i) Asthma, sleep apnoea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder?  Yes  No
- j) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines?  Yes  No
- k) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts?  Yes  No
- l) Anaemia, 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
- m) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine?  Yes  No
- n) Cancer, leukaemia, lymphoma, malignant melanoma or tumours of any kind, malignant or benign?  Yes  No
- o) Any other health impairment or medically treated condition?  Yes  No

## 5. 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, ECGs, x-rays etc), whether conducted on an in-patient or out-patient basis (other than for regular health screening, visa or employment medicals which were confirmed as normal results)?  Yes  No

6. 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

## 7. Do you:

- a) Have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed?  Yes  No
- b) Consume alcoholic beverages?
- Never
- Currently Type of beverage \_\_\_\_\_ Frequency \_\_\_\_\_ Quantity \_\_\_\_\_
- In the past Date stopped \_\_\_\_\_ (dd/mm/yyyy) Reason stopped \_\_\_\_\_

## 8. Within the last 10 years have you:

- a) Been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counselling 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

## Supplementary Information

Question Number	Details (include dates, diagnosis, duration, outcome, treatment and the names of all attending physicians, clinics and hospitals)

**Authorisation To Obtain Information**

I, \_\_\_\_\_ (the "patient") hereby consent to and authorise:

1. any registered medical physician, medical practitioner, medical care provider, hospital, clinic, medical laboratory, government organisation or any other medical or medical related facility that has record or knowledge of my health and medical history or treatments to provide such information about me (including diagnosis, examination and test results, medical reports, treatments and prognosis) with respect to any of my physical or mental conditions and/or treatments to such insurance provider (or its legal representatives) as I may designate from time to time; and
2. the insurance provider (who I have designated) to disclose such medical or other information about me; which has been provided to the insurance provider or which the insurance provider develops during its evaluation of any application for life insurance to:
  - a) its reinsurers;
  - b) any other insurance company that I may designate;
  - c) me;
  - d) my financial adviser representative, when that financial adviser representative is seeking insurance coverage through the insurance provider on my behalf;
  - e) any medical professional that I may designate; and
  - f) any person or entity entitled to receive such information by law.

I acknowledge and agree that:

1. the above authorisation will be valid for two years from the date shown below. A photocopy of the authorisation will be as valid as the original;
2. the above authorisation shall bind my successors and assigns and remain valid notwithstanding my death or incapacity as far as legally possible;
3. information collected under the authorisation may be used by the insurance provider to evaluate my application for insurance, to evaluate a claim for benefits, for reinsurance or for other insurance related purposes; and
4. I and my authorised representative are entitled to a copy of this authorisation.

**Signatures**

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 any application for life insurance for which this medical information was required.

Signature of <b>Patient/Proposed Insured</b>	Place	(Country)
<b>X</b>	Date	(dd/mm/yyyy)

I certify that I have truly and accurately recorded on this form the information supplied by the patient/proposed insured.

Signature of <b>Paramedical Examiner</b> as Witness	Print Name of Paramedical Examiner	
<b>X</b>	Name of Financial Adviser Representative	

**(To be completed by the paramedical examiner )**1. a) Height \_\_\_\_\_ m/ft Did you measure?  Yes  Nob) Weight \_\_\_\_\_ kg/lbs Did you weigh?  Yes  No**Males only: Abdomen** \_\_\_\_\_ inches/ cmc) Any weight change in the past 12 months?  Yes  No

If 'Yes', amount \_\_\_\_\_ kg/ lbs

 Loss Gain

d) Urine Dipstick Result:

Protein	Sugar	Blood

 Urine sample sent to the laboratory (please tick)

2. Blood Pressure Readings:

	Standing	Sitting	Lying
Systolic			
Diastolic			

3. Pulse

Pulse Rate : \_\_\_\_\_ per minute

 Regular Irregular

Type of irregularity \_\_\_\_\_

If extra systoles, No. per minute \_\_\_\_\_

4. Have you examined the patient in the past year?  Yes  NoIs the Patient known or related to you and/or your private patient?  Yes  No

**Paramedical Examiner's Certification And Signature**

How did you identify the patient?

- Driver's License (with photo)       Passport       Other photo ID – please provide details

Examination location:

- Examiner's Office       Residence of Proposed Insured       Business address of Proposed Insured  
 Other - please provide details

Indicate requirements completed

- Blood       Urine       Other

Indicate further instructions (if applicable)

Indicate any requirements not completed and reason

Date provided to Financial Adviser Representative \_\_\_\_\_ (dd/mm/yyyy)

**Signatures**

I hereby certify that I have personally examined the patient and have correctly and fully reported my findings.

Signature of <b>Paramedical Examiner</b>		Paramedical Examiner's Stamp/Chop	
X			
Name of Paramedical Examiner		Paramedical Firm Identification	
Place	(Country)	Date	(dd/mm/yyyy)
Address	Number/Street/Building		
	City		State/Province
	Country		Postal Code
Phone Number			
Examination completed on (date and time)			