

<p>i) AIDS or AIDS related symptoms (or have you ever tested positive for presence of HIV)</p> <p>j) Any other illness, surgery or injury not mentioned above? Give Details : _____ _____ _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Are you presently taking medication of any kind? If so, please give details: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Does your father, mother, sister(s), brother(s) suffer from DM/HT/ASTHMA/TB/STROKE/RENAL/EPILEPSY/TUMORS/MALIGNANCY/ARTHRITIS/OTHERS If so give the following information Who is suffering (father, etc): _____ Age _____ Suffering from: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Do you consume alcohol or tobacco in any form? If yes, please state your normal consumption of : a) Alcohol (beer, wine, spirits): _____ b) Tobacco (cigarettes, cigars, pipe, chewing tobacco or bidis): _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

I confirm that all of the above answers and statements are true and no material facts concerning my past and present state of health and habits have been withheld or omitted. I also agree that any doctor, whether named above or not, who has attended or examined me or who may do so hereafter shall be and is hereby authorised and directed by me to disclose the company any information he may have acquired with regard to myself.

Date : _____
Location : _____

Signature of person to be insured

Signature of medical examiner

Enclosures (if any) 1. _____ 3. _____
2. _____ 4. _____

PART 2: MEDICAL EXAMINER'S FINDING AND ASSESMENT

Please answer each question and where appropriate provider particulars. You are asked not to give the person to be insured any information about the result of your examination.

Section A: Physical Examination

<p>1. Identification</p> <p>a) Do you know the examinee? If yes, personally or professionally : _____</p> <p>b) Nature of ID proof shown to _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Appearance</p> <p>a) What is his / her apparent age? _____ years</p> <p>b) Is the general appearance healthy?</p> <p>c) Is there any defect or deformity, swelling of joints enlargement of thyroid or lymphatic glands?</p> <p>d) Is there any evidence of varicose veins or skin disease?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Measurements and Weights</p> <p>a) Chest measurement in cm (inspiration/expiration) _____ b) Abdomen (in cm) _____</p> <p>c) Height in cm (without shoes) _____ d) Weight in kg (in thin clothes) _____</p> <p>e) Blood pressure reading Systolic/Diastolic: First reading _____ If more than 140/90 please provide two more Second reading _____ Third reading _____</p>	

Section B: Medical Examination

<p>1. Cardiovascular System</p> <p>a) Does the heart sound normal? If no, is there a gallop, murmur, click? Also please give the rate, point of maximum intensity and conduction _____</p> <p>b) State pulse rate: _____</p> <p>c) Describe abnormalities if any. _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Operation and other details</p> <p>a) Is there any evidence of operation, accident or injury?</p> <p>b) State the degree of impairment, if any. Give the location, size and condition of the scar and the nature of operation _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Genito-Urinary system</p> <p>a) Is there any evidence of past or present urinary system disease?</p> <p>b) Is there any evidence of past or present venereal disease?</p> <p>c) Is Hernia present?</p> <p>d) Any palpable mass felt?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Mouth, Eyes, Ears and Throat</p> <p>a) Are the gums, teeth and tongue healthy?</p> <p>b) Is there any evidence of past or present disease of eyes, ears nose or throat?</p> <p>c) If the vision or hearing is affected, give details regarding the degree of abnormality. _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Respiratory System</p> <p>a) Is the chest symmetrical and well formed?</p> <p>b) Are there any symptoms / signs suggesting abnormality / disease of respiratory system?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

<p>6. Abdomen</p> <p>a) Is there any evidence of enlargement of liver or spleen?</p> <p>b) Is there any lump or tenderness of free fluid or any abnormality in the abdomen or pelvis region?</p> <p>c) Is there evidence of piles or fistula?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Abdomen</p> <p>a) Is there any evidence of nervous disease such as paralysis, epilepsy, wasting, tremor, involuntary movements, etc?</p> <p>b) Are the knee jerks and pupil reflexes normal?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Form Female Applicants only</p> <p>a) Is there any disease of breast?</p> <p>b) Do you suspect any disease of uterus, cervix of ovaries?</p> <p>c) Is there any weakness or injury resulting from child bearing or miscarriage?</p> <p>d) Is there any evidence of pregnancy? If there is pregnancy, are any complications expected? _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Urine Dipstick findings (indicate amount with + signs)</p> <p>Sugar _____ Protein _____ Ketons _____ Blood _____</p>	
<p>10. Examiners Comments</p> <p>a) Are you aware of anything about the persons lifestyle which may increase the risk of HIV infection</p> <p>b) Do you consider the health status to be standard (good health-physically and mentally)? (If not state the reason) _____</p> <p>c) Do you suspect any adverse feature in the past history or habits or existence of any disease or any other complaint not noted above?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

I confirm that I have examined the customer after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Date & Location :

<p>_____ Signature of person to be insured</p>	<p>_____ Signature of medical examiner</p>
<p>Enclosures (if any) 1. _____</p>	<p>4. _____</p>
<p>2. _____</p>	<p>5. _____</p>
<p>3. _____</p>	<p>6. _____</p>

FOR OFFICE USE ONLY

Underwriter Comments / Recommendations _____

Despatched to _____ on _____ Approved by _____ Signature & date _____