FijiCare Insurance MEDICAL EXAMINATION FORM

Complete Part I and Sections A, B & C of the Personal Statement below in your own words prior to the examination. The medical examiner will discuss your answers with you and add any details considered appropriate. *Sign the declaration in the examiner's presence.*

PART 1 **Personal statement by Life to be Insured**

Made in connection with an application for:

Life Insurance Disability Insurance Superannuation

REFERENCE

FNPF #: ……..

Policy #: …….....

Company: ……...

On the life of (Full name): …….

Address: …….

Date of Birth: ...../……. /…… Occupation: ……..

Industry in which you work: ……

Name of Agent authorizing the examination: …….....

The Medical Examiner is requested to ensure a clear and complete answer is given to each of the following questions.

A HABITS	**No**	**Yes**	**If Yes, please give details:**
A1 (a) Do you take alcohol?			Form and daily quantity ……
(b) If NO, have you ever taken alcohol?			Form, daily quantity and date ceased ……
A2 (a) Do you smoke?			Form and daily quantity ……
(b) If NO, have you ever smoked?			Form, daily quantity and date ceased ……
A3 (a) Have you used, or injected yourself with any drug not prescribed by a doctor?			If YES, give details ……

B MEDICAL HISTORY	**No**	**Yes**	**For each Yes answer, please provide full details below incl.**
B1 During the last five (5) years have you:			(a) Date
1. Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?			(b) Name and address of institution or attending person (c) Condition (d) Treatment (e) Results and length of time off work
2. Been in hospital, clinic, or nursing home?			**Question No.** …… **Details** *(use all lines as needed from top)* ……
3. Been advised to have an operation?			…… ……
4. Had any tests, including blood tests, ECG, X-rays etc.			…… ……
5. Occassionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers?			…… ……
B2 Do you have contemplate seeking any examination, advice or treatment (including medical or surgical) in the near future?			…… ……
B3 Have you EVER had any of the following:			…… ……
1. Any heart or vascular disorder?			…… ……
2. High blood pressure?			…… ……
3. Pain in the chest?			…… ……
4. Rheumatic fever?			…… ……
5. Asthma?			…… ……
6. Bronchitis (intermittent or longstanding)?			…… ……
7. Any lung complaint?			…… ……
8. Indigestion, gastric or deodesal ulcer?			…… ……
9. Bowel disease?			…… ……
10. Hepatitis, or any liver or gall bladder disease?			…… ……
11. Anaemia, leukemia, haemophitis or any other blood disorder?			…… ……
12. Epilepsy, fainting attacks or fits of any kind?			…… ……
13. Paralysis or stroke?			…… ……
14. Mental illness, depression or nervous condition?			…… ……

B MEDICAL HISTORY Cont'd **No**

15. Kidney or bladder disease (including renal colic, nephritis, pyelitis, cystitis?
16. Diabetes?
17. Cancer or tumor of any kind?
18. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands or recurrent fever?
19. Acquired Immune Deficiency Syndrome (AIDS), any AIDS related conditions or AIDS (HIV) antibodies?
20. Any sexually transmitted disease?
21. Coughing of blood or passage of blood from the bowel or in the urine?
22. Any disease of, or injury to, the neck or spine including back strain, disc disorder, lumbago, fibrositis, sciatica, neuritis etc?
23. Arthritis, gout?
24. Tendonitis, tenosynovitis, "RIS" or regional pain syndrome?
25. An injury, deformity or disease involving any joint or limb?
26. Any impairment of sight, hearing or speech?
27. Any skin disorder?
28. Any congenital abnormality?
29. Hernia (rupture)?
30. Any other operation, disability, illness or injury?

For each Yes answer, please provide full details below including:
(a) Date
(b) Name and address of institutions or attending person
(c) Condition
(d) Treatment
(e) Results and length of time off work

Question No.	**Details** *(use all lines as needed from top)*
……	……
……..	……...
……..	……...
……..	……...
……..	……...
……..	……...
……..	……...
.....	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...
……	……...

If YES, please give details.

C FAMILY HISTORY **No** **Yes**

C1 Has any near blood relative suffered from diabetes, heart disease, mental disorder or breakdown, haemophilia, Huntington's chorea or any hereditary disease?

C2 Please fill in the following schedule of family history details:

	LIVING		**DEAD**	
	Age	**State of Health (if not good, state reason)**	**Age at Death**	**Cause of Death (to be stated fully and exactly)**
Father				
Mother				
Brothers				
Sisters				

DECLARATION

I declare that my answers to the questions in this Personal statement are true and complete. I understand that this Personal statement, forms part of my application for insurance.

Signature of Life to be insured: ……

The above was signed in my presence and discussed where I considered it appropriate.

Date: ……/……/20……... Signature of Medical Examiner: ……

PART 2

CONFIDENTIAL MEDICAL REPORT TO FIJICARE INSURANCE LTD, FIJI ISLANDS

On the medical condition of: ……...
(Name of Examinee)

NOTE:
Information regarding your finding should NOT be given to any other person. Exception may be made, subject to the examinee's consent, if in your opinion there is medical information which should be conveyed to his/her medical attendant.

The Company's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The EXAMINER is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

D INTRODUCTION **No** **Yes**

D1. Are you acquainted with the examinee
(a) Professionally
(b) Personally
If so, how long (a) …… (b) ……..

D2. Is there anything abnormal in appearance, development or behavior?
If YES ……

D3. Is there any indication of past or present abuse of alcohol or of the misuse of drugs?
If YES ……

E MEASUREMENTS

E1. Give the following measurements
(a) Height (without shoes) ……cm
(b) Weight (clothed) ……kg

E2. Chest and Abdomen at umbilicus (next to skin)
(a) Chest Expiration ……cm
(b) Chest Inspiration ……cm
(c) Abdomen ……cm

E3. If chest expansion is less than 5cm comment as to apparent cause or provide peak flow meter reading if available.

F RESPIRATORY SYSTEM **No** **Yes**

F1. Is there any abnormality of the respiratory system to palpitation percussion or auscultation?
If YES ……

F2. Is there any sign of past or present respiratory disease?
If YES ……

G CIRCULATORY SYSTEM **No** **Yes**

G1. What is the rate and character of pulse?
(a) Pulse rate: ……..per minute
(b) Character: ……

G2. What is the position of the apex beat of the heart?
In the ……interspace……cm from mid sternal line.

G3. Is there any evidence of cardiac enlargement?
If YES ……..

G4. Is there any abnormality in the heart abounds or rhythm?
If YES ……..

G5. Is any murmur present?
If YES ……

G6. What is the blood pressure (auscultatory method)?

Systolic ……. Disstolic ……mm Hg
Systolic ……. Disstolic ……mm Hg
Systolic …… Disstolic ……mm Hg

No **Yes**

G7 Is there any abnormality of the peripheral arterial or venous circulation?
If YES ……

G8 Do you consider the heart and vascular system to be abnormal?
If YES ……...

G9 Is the examinee now on treatment for hypertension? If known, please state:
(a) Pre-treatment blood pressure level including date(s)
……
(b) Duration of treatment: ……
(c) Nature of treatment: ……

H DIGESTIVE & LYMPHATIC SYSTEMS

No **Yes**

H1 Is there any abnormality or tongue, mouth or throat?
If YES ……

H2 Is there any abnormality or evidence of disease of any abdominal organ, including lever and spleen?
If YES ……

H3 Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?
If YES ……

H4 Is a hernia present?
If YES ……

I GENTO – URINARY SYSTEM

I1 Examination of the urine
The urine should be passed at the time of examination.
If not please state circumstances:
……
If albumin is found, an early morning specimen should be examined and findings recorded before completing report.
Albumin ……
Glucose ……..

No **Yes**

I2 Is there any evidence of abnormality of the genito-urinary system?
If YES ……

I3 Females – is the examinee pregnant?
If so give expected date of confinement ……

*The diastolic level is to be taken at the cessation of all sound. If the first Systolic reading is above 135 or below 100 or the Diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.

J NERVOUS SYSTEM **No** **Yes**

J1 Is there any defect of vision or abnormality of the eyes?
If YES ……

J2 Is there any defect in hearing or speech?
In case of present or past ear discharge or deafness state result or auriscopic examination
……

J3 Is there any evidence of
(a) mental abnormality?
(b) any disorder of the central or peripheral nervous system?
If YES ……

K MUSCULO – SKELETAL SYSTEM & SKIN

No **Yes**

K1 Is there any abnormality of the form or function of:
(a) the joints?
If YES ……

(b) the muscles or connective tissues?
If YES ……

(c) the back or neck including the cervical and lumbar spine?
If YES ……

K2 Is there evidence of any disorder of the skin?
If YES ……

L SUMMARY **No** **Yes**

Do you consider any medical attendant's reports or any special tests are required?
(No special tests are to be carried out in connection with the application for insurance without the Company's authority)
If YES ……
……..

Do you consider the person examined, likely to require any surgical operation?
If YES ……
……...

Comment fully on any unfavorable features (either physical or mental) which could either reduce life expectancy or cause disablement of the person examined.
(a) As disclosed in Sections A, B & C of this form:
…….
……...
(b) disclosed by your medical examination: ……
……...

IMPORTANT: This Medical Examination is a matter of importance to the person you have just examined and it would be appreciated if you would forward the report without delay to:

FijiCare Insurance Limited
Level 9 FNPF Place, Victoria Parade,
Suva, Fiji.
P.O. Box 15808, Suva, Fiji.

Ph. (679) 3302 717
Fx. (679) 3302 119

Dated at ……on ……/……./20……

Signature of Medical Examiner ……...

Qualification: ……...

PAYMENT OF FEE

Name ……

Address ……

……..

Telephone ( ) …….