

**MEDICAL EXAMINER'S REPORT
 CONFIDENTIAL**



ALL PARTS TO BE COMPLETED BY THE MEDICAL EXAMINER

PART 1: PERSONAL DETAILS

Please ask the person to be insured the following:

Surname: _____ Given name(s): _____ Mr. / Mrs. / Ms. / Miss
 Marital Status: (married, single, divorced, separated, widowed, common-law): _____ Sex: male / female
 Date of Birth: _____ Occupation: _____
 (day/ month/year)
 Address: _____
 No. Street City Province Postal Code

PART 2: MEDICAL HISTORY

Please ask the person to be insured the following questions and qualify if necessary:

- 1a) Are you in good health? **Yes/No**
- b) Do you usually enjoy good health? **Yes/No**

If you responded **No** to question 1a or 1b, please provide **full details, dates, and name and address** of Medical Practitioner consulted: _____

- 2) **Have you at any time had investigations for, suffered from or had symptoms of:**
 - a) Blackouts, depression, anxiety state, mental disorder or nervous disease? **Yes/No**
 - b) Tuberculosis, pleurisy, asthma, pneumonia, bronchitis, persistent cough or spitting of blood? **Yes/No**
 - c) Palpitation, fainting, undue shortness of breath, raised blood pressure or any heart trouble? **Yes/No**
 - d) Chronic indigestion, gastric or duodenal ulcer or any other disorder of the stomach, liver or bowels?..... **Yes/No**
 - e) Diabetes or any disorder of the kidneys, bladder or urinary system? **Yes/No**
 - f) Any form of sexually transmitted disease including Hepatitis B, C and AIDS? **Yes/No**
 - g) Rheumatism, arthritis, gout, rheumatic fever, back trouble, lumbago or sciatica? **Yes/No**
 - h) Enlarged glands or tumours, cysts or swellings? **Yes/No**
 - i) Any disease, injury or disability not mentioned above? **Yes/No**

For each Yes answer under question 2, please give full details (dates and name and address of Medical Practitioner consulted, diagnosis, prognosis, treatments, dosage etc). If you require more space, please attach a separate sheet of paper. Please ensure you date and sign any additional pages and attach them to this form.

Question #	Date	Details

- 3) Have you had or are you contemplating any other medical investigations, blood tests, chest x-rays or check-ups? **Yes/No**
- 4) Are you taking any medicine or drug at the present time? (whether prescribed or not) **Yes/No**
- 5) Have you ever taken drugs other than for medical purposes? **Yes/No**
- 6) Have you undergone or are you in prospect of undergoing any operation? **Yes/No**

If you responded **Yes** to question 3, 4, 5, or 6, please provide **full details and dates**:

Question #	Date	Details

7) How many days have you lost from work in the last year through illness or injury? _____

8a) How much to do smoke **per day**? Cigarettes _____ Cigars _____ Pipe _____

b) How much to do smoke **per week**? Cigarettes _____ Cigars _____ Pipe _____

c) If you have given up smoking, when did you stop? _____

d) Was this on medical advice? **Yes/No** If **yes**, please state **why**: _____

9a) Indicate your average weekly consumption of units of alcohol:

Note: 1 unit is equivalent for 1/2 pint of beer or lager, 1 glass of wine or 1 ounce of spirits

Beer _____ Wine _____ Liquor _____

b) If abstained, how long have you been so? _____

c) Have you been advised by a medical practitioner to reduce your consumption of alcohol? **Yes/No** If **yes**, please provide **full details**: _____

10) Have any of your near relatives, whether living or dead, suffered from epilepsy, diabetes, mental disorder, cancer, stroke or disease? **Yes/No** If **yes**, please provide **full details and dates**: _____

11) Family history:

If Living
Present age State of health

If Dead
Age at death Cause of death

Father	
Mother	
Brother/Sister	
Brother/Sister	
Brother/Sister	
Brother/Sister	

I consent to William J. Sutton and Co. Ltd. making known, in my best interests, to my doctor (whose name and address I have provided) any medical information that is elicited by independent medical examination that may be relevant to my care of which he or she may be unaware. **I declare that the particulars given are true and that I have not withheld any material information.**

Signature of proposed Insured: _____ Date: _____
(day/ month/year)

Signature of the Medical Examiner: _____ Date: _____
(day/ month/year)

PART 3: EXAMINATION

You are particularly requested **not** to give details of your report to the person to be insured.

Please report on the following:

1) Have you any personal or professional knowledge of the proposed Insured? **Yes/No** If **yes**, please provide **full details**:

2) Does he/she look older than the stated age? **Yes/No** If **yes**, please provide **full details**:

3) Describe their general appearance and build: _____

4) **Height:** With/ Without shoes? _____ feet and inches **or** _____ cms

Chest girth: On inspiration? _____ ins/cms On expiration? _____ ins/cms

Weight (actual): _____ pounds/kgs

Has the weight increased or decreased in the past year?

Abdominal girth: _____ ins/cms

5) Please examine the proposed Insured and report on the following. Do you detect abnormality in:

- a) Mouth, Pharynx, Ears (including hearing) **Yes/No**
- b) Cardiovascular system (if any abnormality, give result of exercise tolerance test.) Record blood readings in question 7 below **Yes/No**
- c) Respiratory system **Yes/No**
- d) Nervous system (including eyes and visual acuity) **Yes/No**
- e) Abdomen **Yes/No**
- f) Hernial orifices **Yes/No**
- g) Musculo skeletal (please evaluate spinal movements) **Yes/No**
- h) Genito-Urinary System **Yes/No**

6) Urinalysis:

- a) Is albumen present? **Yes/No** If **yes**, please state **amount**: _____
- b) Is sugar present? **Yes/No** If **yes**, please state **amount**: _____
- c) Is blood present? **Yes/No** If **yes**, please state **amount**: _____

7) Blood Pressure:

First reading Subsequent readings * Further readings on another day †

Systolic _____

Diastolic (4th phase) _____

Diastolic (5th phase) _____

Pulse rate _____ Date _____

(day/ month/year)

*Required if the first reading is over 140 (systolic) or 95 (4th phase) 90 (5th phase), or if pulse rate is abnormal.

† Required if the blood pressure readings on the first day are persistently outside the limits referred to above.

8) Female applicants only:

a) Has there been any apparent abnormality in the uterine functions? **Yes/No** If **yes**, please provide **details:**

b) Has she borne children? **Yes/No** If **yes**, state how many: _____

c) Has her health been affected? **Yes/No** If **yes**, please provide **details:** _____

d) Is she pregnant now? **Yes/No**

9) Male applicants only:

Do you find anything to suggest that the applicant may be at risk of infection by the Human Immunodeficiency Virus or any other sexually transmitted diseases? **Yes/No** If **yes**, please provide **details:**

10) General remarks:

Please use this space to amplify the information given in the main body of the report, particularly if abnormality has been found.

11) Do you think the proposed Insured, on careful examination and on consideration of the medical record and family history disclosed to you is an average risk for:

a) Life insurance? _____

b) Group Income Protection Cover terminating at age 65? (non- cancellable disability coverage in case of sickness, accident or operation) _____

Signature: _____

Date: _____
(day/month/year)

Qualifications: _____

Date: _____
(day/month/year)