This form must be signed by Proposed Life Insured in the presence of the Medical Examiner

Part 1 – To be completed by the Proposed Life Insured

The Proposed Life Insured must complete Sections A to D of Part 1 of this form

Application Reference Number

Section A – Personal Details

Given Name(s)

Family Name

Date of Birth D D M M Y Y Y Y

Please provide Name, Address and Telephone Numbers of the Doctor, Clinic or Hospital most familiar with your Medical History:

Postal Code

Telephone

Section B – Medical History

1. Date of and reason/s for your most recent consultation with a Medical Practitioner
2. What medication or treatment was prescribed?

If you answer "Yes" to any of these questions, please provide additional details in the space provided on page 3

1. Have you ever been treated for, or had any known indication of, any of the following?	**Yes**	**No**
a. Disorder of eyes, ears, nose or throat?		
b. Dizziness, fainting, convulsions, abnormal headache; speech defect, paralysis or stroke; psychiatric or nervous disorder?		
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disease?		
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?		
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?		
f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of the kidney, bladder, prostate or reproductive organs?		
g. Diabetes, thyroid or other endocrine disorders?		
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?		
i. Lameness, deformity, mutilation or amputation?		
j. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or any immune disorder?		
k. Allergies, anaemia or other disorder of the blood?		

Section B – Medical History (continued)

If you answer "Yes" to any of these questions, please provide additional details in the space provided on page 3

	Yes	No
4. Do you smoke, use any other form of tobacco, or any other nicotine-based products? If "Yes", what form and what is your average daily consumption? (e.g. pipe tobacco, shisha, chewing tobacco, nicotine patches or gum, electronic cigarettes)	☐	☐

5. Do you drink alcohol? If "Yes", how many units do you consume on average per week? (1 unit = 1 measure of spirits,1 glass of wine, or ½ pint of beer) ☐ ☐

6. Within the past five years, have you used:

a) barbiturates, sedatives or tranquilisers habitually? ☐ ☐

b) LSD, marijuana, cocaine or any amphetamine? ☐ ☐

c) heroin, morphine or any other narcotic drug? ☐ ☐

7. Within the past five years, have you been diagnosed with cancer of the nodes (glands), experienced enlargement of the lymph nodes, abnormal diarrhoea, unusual skin lesions, unexpected infections or received a blood transfusion? ☐ ☐

8. Within the past 10 years, have you been treated for alcohol or drug abuse? ☐ ☐

9. Are you now under medical observation or receiving treatment for any condition? ☐ ☐

10. Other than due to intentional weight loss or pregnancy; has your weight changed by more than 5kg in the last 12 months? ☐ ☐

11. Other than already mentioned; within the past five years, have you:

a. had any psychiatric or physical disorder not already mentioned? ☐ ☐

b. had any check-up, consultation, illness, injury or surgery? ☐ ☐

c. been a patient in a hospital, clinic, sanatorium or other medical facility? ☐ ☐

d. had an electrocardiogram, X-ray or other diagnostic test? ☐ ☐

e. been advised to have any diagnostic test, hospitalisation or surgery which you did not complete? ☐ ☐

12. Have any of your immediate family (including your spouse) ever been treated for tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, psychiatric illness or AIDS? ☐ ☐

13. For females only:

a. Have you ever had any disorder related to menstruation, pregnancy, female organs or breasts? ☐ ☐

b. To the best of your knowledge, are you currently pregnant? ☐ ☐

Question Reference Number	If you answered "Yes" to any of the questions above, please provide as much additional information as you can remember in the space provided below; including dates, diagnoses, duration, and the name and address of the attending physician or medical centre you attended for each condition noted.

If there is insufficient space, please continue on a separate sheet, ensuring that you sign and date any additional pages.

Section C – Family History

Please provide details of your immediate family's history below. In particular, whether any of your immediate family has died or suffers from heart disease, cancer, multiple sclerosis, diabetes or from any other hereditary disorder.

	Living Family Members				Deceased Family Members	
Relation	**Age Now**	**In good health?**	**Health Conditions Noted**	**Age at Onset**	**Age at Death**	**Cause of Death**
Father		Yes No				
Mother		Yes No				
Brother/Sister		Yes No				
Brother/Sister		Yes No				
Brother/Sister		Yes No				
Brother/Sister		Yes No				

Section D: Declaration by Proposed Insured

To be signed by Proposed Life Insured in the presence of the Medical Examiner

I declare that the above information is true, complete and precise, and I agree that, together with the proposal and declaration, it shall form the basis of the Policy.

I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual, organisation or government office that has any records or knowledge of me or my health to disclose such information to Guardrisk Life International Limited, or Unisure Limited. This authorisation shall irrevocably bind my successors and assignees and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

Signed at _____ this _____ day of _____ 20 _____

Signature of Proposed Life Insured

Signature of Medical Examiner

Part 2 – Medical Examiner's Report

MEDICAL EXAMINATIONS MUST BE MADE AND COMPLETED IN PRIVATE

The Medical Examiner must ask every question and the answers must be recorded in ink in the Examiner's own handwriting.

Please print full name and address of the Medical Examiner.

Please make a careful examination of the heart and lungs using a stethoscope against bare skin.

Please bear in mind that, for the medical history of some individuals, your findings may have particular significance. Please, therefore, include any comments you consider relevant to your findings in the spaces provided for additional details.

Section A – Build and Physical Condition

Height (without shoes)	cm	Weight (in clothes)	kg
Chest measurement (inspiration)	cm	Chest measurement (expiration)	cm
Abdomen measurement	cm	Hip measurement	cm

Did you take these measurements? **Yes** **No**

Section B – Cardiovascular System

1. Pulse

	Resting	After Exercise	3 Minutes Later
Irregularities per minute			

2. Blood Pressure

Please record all readings taken. Please take two additional readings at intervals if:

- Proposed Life Insured has history of hypertension, or
- if first reading is over 135 systolic or over 85 diastolic, or
- if first reading is below 90 systolic or below 60 diastolic.

	First Reading	Second Reading	Third Reading
Systolic			
Diastolic			

Is Diastolic at:

Disappearance of All Sounds (Phase V) ☐ Change of Sound (Phase IV) ☐

3. Irregularities

Please note presence of any of the following:

	Yes	No		Yes	No
Enlargement	☐	☐	Dyspnoea	☐	☐
Murmur	☐	☐	Oedema	☐	☐

If you have marked "Yes" for any of the above, please provide details (use additional sheets if necessary).
Please ensure it is clear to which question your additional notes relate.

Location of Murmur

	Yes	No		Yes	No
Constant	☐	☐	Inconstant	☐	☐
Transmitted	☐	☐	Localised	☐	☐
Systolic	☐	☐	Presystolic	☐	☐
Diastolic	☐	☐	Soft (Gr 1-2)	☐	☐
Mod (Gr 3-4)	☐	☐	Loud (Gr 5-6)	☐	☐

After Exercise

	Yes	No		Yes	No
Increased	☐	☐	Absent	☐	☐
Unchanged	☐	☐	Decreased	☐	☐

Section C – Respiratory System

If you answer "Yes" to any of these questions, please provide additional details in the space provided on page 6

	Yes	No
1. Are there signs of decreased chest expansion?	☐	☐
2. Are there signs of abnormal dullness to percussion?	☐	☐
3. Are there any abnormal sounds heard on auscultation?	☐	☐
4. Is the Proposed Life Insured's voice normal?	☐	☐

Section D – Genitourinary System

FOR MEN

1. Are there any indications of genital organ disease (testes, epididymis, prostate)?	☐	☐
2. Is there gynaecomastia?	☐	☐

FOR WOMEN

1. Are there any indications of genital organ disease?	☐	☐
2. Are there any breast abnormalities?	☐	☐

Please submit a urine sample for Microscopic Chemical Urinalysis and attach the results to this report.
The urine sample must be emitted on the Medical Examiner's premises.

Section E – Gastrointestinal System

1. Are there any abnormalities of the mouth, tongue or pharynx?	☐	☐
2. Are there any abnormalities of the abdomen on palpation?	☐	☐
3. Are there any hernias?	☐	☐
4. Are there any haemorrhoids?	☐	☐

Section F – Central Nervous System

1. Are the papillary, abdominal or tendon reflexes abnormal?	☐	☐
2. Are there any abnormalities of gait and mobility?	☐	☐
3. Are there any indications of paralysis?	☐	☐
4. Are there any indications of autonomic nervous dysfunction?	☐	☐
5. Are any psychiatric or neurological abnormalities indicated?	☐	☐

Section G – Skin and Teguments

1. Are there any indications of any of the following?	☐	☐
a. Jaundice or cyanosis?	☐	☐
b. Skin eruption, cyst, tumour, varicosities or oedema?	☐	☐
c. Lymphadenopathy?	☐	☐
d. Tophi or xanthomata?	☐	☐
2. Are there any major scars?	☐	☐

Section H – General Observations

	Yes	No
1. Are there any indications of tobacco use, or of alcohol or drug abuse?	☐	☐
2. Are any thyroid abnormalities indicated?	☐	☐
3. Are there any bone, joint or spine abnormalities?	☐	☐
4. Are there any malformations, mutilations or amputations?	☐	☐
5. Are there any eye, ear or nose abnormalities?	☐	☐

If vision or hearing is markedly impaired, please record the degree of impairment and correction.

6. How would you summarise the Proposed Life Insured's overall state of health?

☐ Good ☐ Average ☐ Below Average ☐ Poor

If "Below Average" or "Poor" please give your reasons for this assessment.

Question Reference Number	If you answered "Yes" to any of the questions above, please provide as much additional information as you can remember in the space provided below; including dates, diagnoses, duration, and the name and address of the attending physician or medical centre you attended for each condition noted.

If there is insufficient space, please continue on a separate sheet, ensuring that you sign and date any additional pages.

Section H – General Observations (continued)

	Yes	No
7. Has the Proposed Life Insured ever consulted you professionally?	☐	☐
8. Do you know the Proposed Life Insured in a non-professional capacity?	☐	☐
9. Based on your knowledge of the Proposed Life Insured, in your professional opinion, are there any aspects of their environment, occupation or lifestyle which could negatively impact their general state of health?	☐	☐
10. Do you have any reservations concerning the longevity of the Applicant?	☐	☐

Name of Insurance Agents

11. Are you in any way related to the Insurance Agents? If "Yes", how are you related?	☐	☐

Part 3 – Medical Examiner's Statement

I have examined

The Examination was made in private at

and completed at _____: _____ am/pm

on _____ /_____ /20_____

- ☐ My Consulting Rooms
- ☐ Residence of Proposed Life Insured
- ☐ Business Premises of Proposed Life Insured

Signature of Medical Examiner

Please complete in BLOCK letters or use rubber stamp

Name

Address

Postal Code

Telephone

Email

Service and Administration Contact Details

If we can help you with more information about our product offerings, or if you would like to meet with one of our product experts, please contact us:

South Africa
3rd Floor
139 Greenway
Greenside
Johannesburg
2034

Tel: +27 10 592 1752

United Kingdom
Holland House
4 Bury Street
London
EC3A 5AW
United Kingdom

Tel: +44 207 118 1455

Asia
D4-6-9 Solaris Dutamas
Jalan Dutamas 1
50480
Kuala Lumpur
Malaysia

Tel: +60 3 6206 1616

Central email enquiries: admin.life@unisuregroup.com
Please specify within your query which country or area your enquiry relates to

life.unisuregroup.com