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

Application Reference Number

Personal Details

Given Name(s)

Family Name

Date of Birth DD/MM/YYYY

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

Postal Code

Telephone

Medical History

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

Declaration by Proposed Insured

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

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.

Signature of Proposed Life Insured

Date DD/MM/YYYY

Signature of Medical Examiner

Date DD/MM/YYYY

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.

	Yes	No
Are you the Proposed Life Insured's usual medical practitioner?	☐	☐

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**

Please state your impression of the general appearance of the Proposed Life Insured.
(Anaemic, Athletic, Flabby, Flushed, Muscular, Pale, Thin, etc)

Cardiovascular System

Resting Pulse Rate | Irregularities per minute

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			

Abnormalities

	Yes	No
During your examination, did you notice any abnormalities such as Heart Murmur, Dyspnoea or Oedema?	☐	☐

If "Yes", please provide details (use additional sheets if necessary).

General Observations

	Yes	No
1. Are there any indicators of tobacco use, or alcohol or drug abuse?	☐	☐

If "Yes", please provide details (use additional sheets if necessary).

General Observations (continued)

Urine Examination (The urine sample must be emitted on the Medical Examiner's premises)

Unless a Microscopic Chemical Urinalysis has be requested, please record the results of a Dipstick Urinalysis below.
If present, please state value and unit of measurement in the space provided.

Appearance	Albumin? Yes ☐ No ☐	Blood? Yes ☐ No ☐	Glucose? Yes ☐ No ☐

2. Any other urine abnormalities noted? Yes ☐ No ☐

If "Yes", please provide details (use additional sheets if necessary).

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

Please complete in BLOCK letters or use rubber stamp

Name _____

Address _____

_____

Postal Code _____ Telephone _____

Email _____

Qualifications of Medical Examiner _____

_____

_____

_____

Signature of Medical Examiner