

Medical examination report

Instructions

Please complete this form in English using CAPITAL letters.

Please take reasonable care to answer all the questions accurately. If you do not answer all the questions or withhold information, this may influence the assessment or acceptance of the policyholder's application for insurance and as a result the cover may be cancelled or its terms changed or a claim may be rejected in full or part.

If there is insufficient space for any answer, please continue on a separate sheet of paper and attach it to this questionnaire. Please tick if a separate sheet is attached. ☐

Please note: additional tests are also required, please refer to the additional medical examination checklist on page 15 of this form.

Policy details

Policyholder name

Policy number

Private and confidential

1 Personal details of group member

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please give details)

Forename(s)

Family name

Please give details of any previous names used (including maiden name)

Date of birth

Start date of employment

Employer

Occupation

2 Contact details

Address of group member

Home telephone number

Mobile telephone number

Email address of the group member (optional)

By providing my email address I authorize Zurich to contact me and send me information or data by email.

We adhere to strict confidentiality procedures when we communicate with our customers. For security purposes, we will regard the details you have provided above as your authorized contact details; it is therefore important that they are accurate and that you let us know if any of these details change.

Sections 3 to 9 to be completed by the group member

The examining doctor is requested to review these answers with the group member.

3 Family history

Please provide details of your family history below. Of particular importance is where your father, mother or any of your brothers or sisters has died of or suffered from heart disease, cancer, multiple sclerosis or diabetes before the age of 65 or from a familial/hereditary disorder.

Relation	Age now/Age at death	State of health/Cause of death	Age at onset of disease
Father			
Mother			
Brother(s)			
Sister(s)			

4 Medical history

Is your ability to work reduced?

☐ Yes ☐ No

If 'Yes' please give details

Since when and for how long?	Specific nature of condition

Have you been unable to work for more than four consecutive weeks during the last five years?

☐ Yes ☐ No

If 'Yes' please give details

Time off work	Specific nature of condition

Please note that if you answer 'Yes' to any of the questions below you should provide full details, including dates, diagnoses, durations, outcome and the names and addresses of attending physicians in the space provided at the end of this section.

Have you ever had or do you now suffer from any disease, abnormality or problem related to:

(a) **the respiratory organs** – such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?

☐ Yes ☐ No

(b) **the heart or vascular system** – such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, stroke, phlebitis, varicose veins or other disorders?

☐ Yes ☐ No

(c) **mental health** – such as any psychiatric disorders, e.g. depression, anxiety, panic attacks, Post Traumatic Stress Disorder, schizophrenia, Bipolar disorder etc.?

☐ Yes ☐ No

(d) **the nervous system** – such as epilepsy, dizziness, paralysis, neuritis, migraine or other disorders?

☐ Yes ☐ No

(e) **the digestive system** – such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, polyps, etc?

☐ Yes ☐ No

(f) **the genito-urinary system** (kidneys, ureters, bladder or prostate) – such as urinary calculus, blood or albumin in the urine or other disorders?

☐ Yes ☐ No

(g) **metabolism or blood** – such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anaemia, coagulation abnormalities or other disorders?

☐ Yes ☐ No

(h) **the immune system or infectious diseases** – such as AIDS, HIV infection, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?

☐ Yes ☐ No

(i) **the skin** – such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?

☐ Yes ☐ No

- (j) **the musculoskeletal system** (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons) – such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders? ☐ Yes ☐ No
- (k) **the eyes** – such as decreased visual acuity or refraction power (short or far sightedness), retinal disease or other disorders? ☐ Yes ☐ No
- (l) **the ears** – such as hearing difficulties, inflammation or other disorders? ☐ Yes ☐ No
- (m) **other illnesses** – abnormalities or problems not listed above, such as congenital defects, deformities, cysts, tumors, cancer, etc? ☐ Yes ☐ No
- (n) Have you ever been examined, received treatment or been operated on in hospital or a similar institute? ☐ Yes ☐ No
- (o) Have you ever been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned? ☐ Yes ☐ No
- (p) Is a hospital stay or surgery planned? ☐ Yes ☐ No
- (q) Have you ever been given or prescribed any medication for a period of more than four weeks? ☐ Yes ☐ No
- (r) Have you ever undergone any special examinations/tests during the last five years, such as X-rays, CT scan, MRI (magnetic resonance imaging), ultrasound, echocardiogram, electroencephalogram, endoscopy or other tests? ☐ Yes ☐ No
- (s) Have you had an HIV test which showed a positive result? ☐ Yes ☐ No
- If 'Yes' please give date of positive result

5 For FEMALE applicants only

- (a) Are you pregnant? ☐ Yes ☐ No
- (b) If yes, please tell us how many weeks?
- (c) Do you have any complications in the pregnancy, or did you have any complications in your previous pregnancies? ☐ Yes ☐ No
- (d) Have you ever had, or do you now have, any disorder of the female organs (e.g. vaginal bleeding or abnormal PAP smears, breast lumps or ovarian cysts)? ☐ Yes ☐ No

If you answered 'Yes' to any of the questions in section 4 Medical history, please provide full details.

Question number	Date(s)/Duration	Time off work	Specific nature of condition	Treatment and result

6 Social history

(a) Have you ever taken drugs other than for medicinal purposes?

☐ Yes ☐ No

If 'Yes' please give details

(b) Do you currently smoke or consume tobacco?

☐ Yes ☐ No

If 'Yes' please state amount per day

<u>Cigarettes</u>	<u>Cigars</u>	<u>Grammes of pipe tobacco</u>
<u>Chewing tobacco</u>	<u>Other e.g. Shisha (please give details)</u>	

(c) Do you drink alcohol?

☐ Yes ☐ No

If 'Yes' please state amount per week

<u>litres/beer</u>	<u>glasses/wine</u>	<u>measures/spirits</u>
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(d) Do you currently take any medication such as painkillers, sleeping tablets or tranquillizers, or any other medication?

☐ Yes ☐ No

If 'Yes' please give details

Since when	Amount per week	Reason

(e) Do you practice sports?

☐ Yes ☐ No

If 'Yes' please give details

Which	How often

(f) When and why did you last consult a doctor before this consultation?

Date	Reason

Result

Doctor

Address

7 Privacy Notice

The personal information requested in this form is collected and used by Zurich as Data Controller under applicable data protection laws. Full details of our privacy notice can be found at www.zurichinternational.com/im/legal/privacy.

8 Declaration and consent

Declaration

- I declare that the information and statements made in this form, to the best of my knowledge, are true and complete.
- I understand that Zurich will only communicate with me using the contact details that I have supplied. Where I have provided more than one form of contact details, the most appropriate method of communication will be used depending on the urgency and sensitivity of the information.
- I understand that the insurance cover is subject to the terms and conditions between Zurich and the policyholder. It does not constitute any legal basis for a direct claim by me against Zurich.
- I understand that Zurich will communicate the terms of providing cover, including any exclusion, or any refusal or postponement of cover or any loading to be applied resulting from Zurich’s medical underwriting decision to the policyholder or their broker or intermediary.
- I understand that Zurich may seek independent verification (if considered necessary) of any information provided in this form.

Consent

- I consent to Zurich processing my medical and health information provided in this form, and any supplemental form, and authorize the processing of any information provided by any medical practitioner who has attended me, in order to underwrite the insurance cover requested by the policyholder.
- I understand I have the right to withdraw this consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.
- If I do not give my consent then I understand that Zurich will be unable to provide the proposed level of cover requested by the policyholder and may result in the loss of benefits.

Signature of group member

Date

D

D

M

M

Y

Y

Y

Y

Sections 9 and 10 to be completed by the examining doctor.

Note for examining doctor: please undertake the necessary examinations marked and record results. Additional tests are also required, please refer to the additional medical examination checklist on page 15 of this form. Additional tests will only be paid for by Zurich if we have specifically requested them.

9 Confidential medical examination

1 Date of examination

D	D	M	M	Y	Y	Y	Y
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2 Have you previously examined or treated the group member?

☐ Yes ☐ No

If 'Yes' please give details

Date	Specific nature of condition	Treatment	Result

3 Are you related to the group member?

☐ Yes ☐ No

If 'Yes' please give details

Relationship

4 Height, weight, abdomen (at umbilicus) of the group member?

☐ Yes ☐ No

If 'Yes' please give details

Height	mtrs/cms	Weight	kgs	Abdomen	cms
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5 Does the person look healthy?

☐ Yes ☐ No

If 'No' please give details

6 **Skin** – any signs of skin disease (e.g. rash, ulcer, swelling), scars, suspicious naevi?

☐ Yes ☐ No

If 'Yes' please give details

7 Respiratory organs

(i) Any hoarseness or coughing?

☐ Yes ☐ No

If 'Yes' please give details

(ii) Any abnormality on percussion and auscultation?

☐ Yes ☐ No

If 'Yes' please give details

Confidential medical examination (continued)

(iii) Any other signs of disease of the respiratory system?

☐ Yes☐ No

If 'Yes' please give details

8 Cardiac and peripheral vascular system

(i) Any heart murmurs, organic heart murmurs or other abnormal signs?

☐ Yes☐ No

If 'Yes' please give details

(ii) Is there any evidence of:

abnormal heart sounds (intensity, split)?

☐ Yes☐ No

any systolic irregularities?

☐ Yes☐ No

any diastolic irregularities?

☐ Yes☐ No

If 'Yes' to any of the above questions, please give details

(iii) Pulse rate and blood pressure (if reading is higher than 140/90, please take a second reading after five minutes)

1st pulse

2nd pulse

Blood pressure

Blood pressure

Reading after

mins

(iv) Any irregularity in the pulse rhythm?

☐ Yes☐ No

If 'Yes' please give details

(v) Is pulsation of the pedal arteries absent or weak?

☐ Yes☐ No

If 'Yes' please give details

Confidential medical examination (continued)

(vi) Any signs of insufficiency or decompensation (shortness of breath, cyanosis, oedema)?

☐ Yes ☐ No

If 'Yes' please give details

(vii) Any varicose veins?

☐ Yes ☐ No

If 'Yes' please give details

9 Digestive system and abdomen

(i) Any abnormalities of the mouth, teeth or throat?

☐ Yes ☐ No

If 'Yes' please give details

(ii) Any abnormalities or diseases of the abdominal organs and/or the digestive system?

☐ Yes ☐ No

If 'Yes' please give details

(iii) Any presence of a hernia?

☐ Yes ☐ No

If 'Yes' please give details

10 Genito-urinary system

(i) Any abnormalities or diseases of the genito-urinary system?

☐ Yes ☐ No

If 'Yes' please give details

Confidential medical examination (continued)

(ii) For MALES only

Any disease of the testicles, prostate etc?

☐ Yes ☐ No

If 'Yes' please give details

Any abnormality detected on rectal examination? (required at age 50+)

☐ Yes ☐ No

If 'Yes' please give details

(iii) For FEMALES only

Any signs of abnormalities of uterus, ovaries or breast?

☐ Yes ☐ No

If 'Yes' please give details

11 Nervous and mental system/sense organs

(i) Any signs of disease of the sense organs, particularly reduced sight or hearing?

☐ Yes ☐ No

If 'Yes' please give details

(ii) Any abnormal reflexes (e.g. pupillar, abdominal, patellar, Achilles tendon, Babinski)?

☐ Yes ☐ No

If 'Yes' please give details

(iii) Any signs of mental or nervous system abnormalities (e.g. anxiety, depression, sleeping disorders)?

☐ Yes ☐ No

If 'Yes' please give details

Confidential medical examination (continued)

12 Musculoskeletal system

- (i) Any signs of back, spine or neck abnormalities/diseases?

☐ Yes ☐ No

If 'Yes' please give details

- (ii) Any signs of muscular, bone or joint abnormalities/diseases?

☐ Yes ☐ No

If 'Yes' please give details

13 Endocrine/lymphatic system

- (i) Any enlarged lymph nodes?

☐ Yes ☐ No

If 'Yes' please give details

- (ii) Is the thyroid gland abnormal in size or texture?

☐ Yes ☐ No

If 'Yes' please give details

- (iii) Any signs of hormonal imbalance (e.g. adrenal gland, gonads, thyroid gland)?

☐ Yes ☐ No

If 'Yes' please give details

14 General

- (i) Any other abnormal findings not mentioned previously?

☐ Yes ☐ No

If 'Yes' please give details

- (ii) Any suspicion of alcohol, nicotine, medication abuse or narcotic drug use?

☐ Yes ☐ No

If 'Yes' please give details

Confidential medical examination (continued)

(iii) Is the person's occupation or lifestyle likely to have a detrimental affect on his/her health?

☐ Yes ☐ No

If 'Yes' please give details

(iv) Are you aware of any other risk factors?

☐ Yes ☐ No

If 'Yes' please give details

(v) Is any further action considered necessary (e.g. recheck, clarification, therapy, change of lifestyle)?

☐ Yes ☐ No

If 'Yes' please give details

15 Final evaluation

(i) Please summarise your assessment of the group member's condition with regard to life and/or disability insurance.

Life

☐ Very favourable ☐ Favourable ☐ Average ☐ Lower than average ☐ Unfavourable

Disability

☐ Very favourable ☐ Favourable ☐ Average ☐ Lower than average ☐ Unfavourable

Recommendation/additional comments

10 Declaration

Important – please ensure that all questions are answered and the group member has signed the declaration.

If you detect some abnormality which the group member may or may not be aware of, and which you consider requires further investigation, then please advise what course of action you have taken.

I hereby confirm that I have questioned and examined the group member and have answered the above questions to the best of my knowledge and in good faith.

Signature

Date

D

D

M

M

Y

Y

Y

Y

Name

Professional qualifications

Address

Doctor’s telephone number

Doctor’s email address

Stamp of doctor

Additional medical examination checklist (Laboratory and ECG tests)

Note for examining doctor: The group member requires the following medical tests to be undertaken. Please return a copy of the test results on the clinic’s headed paper. Please note the group member has been advised what tests are required (for compulsory schemes Test 1 and 2).

Test 1	Test 2
• HbA1c	• SGPT (ALT)
• Full Lipid Profile	• SGOT (AST)
• HIV test	• Gamma-GT (GGT)
• HBsAG	• Creatinine (S.Cr)
• Exercise ECG (bicycle or treadmill) for all lives aged 50+ (please enclose the ECG tracings)	• Complete Blood Count
	• Exercise ECG (bicycle or treadmill) for all lives aged 50+ (please enclose the ECG tracings)

Please note that the tests detailed are the only tests that Zurich will pay for. Additional tests will only be paid for by Zurich if we have specifically requested them.

Important: please do not give the group member any information that might interfere with our underwriting decision. If you detect some abnormality which the group member may or may not be aware of, and which you consider requires further investigation, then please advise what course of action you have taken.

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