RESOLUTION life

Boskruin Office Park,
President Fouche Avenue,
Boskruin, 2154
(Entrance Boskruin Village Centre)

P O Box 1555, Fontainebleau, 2032

Telephone: 0861 543 326
Facsimile: 086 559 9451

CONFIDENTIAL MEDICAL REPORT

INDIVIDUAL POLICY ☐ CORPORATE SCHEME ☐

Tarif Code A1102 payable to General Practitioners

Tarif Code A2100 payable to Physician Specialists

IMPORTANT:

1. Photographic identification (only ID book, passport or card –type driver's licence) must be produced. Photocopies or faxed copies are not acceptable.
2. This examination may only be conducted in a fully equipped surgery by a registered medical practitioner. Home visits are not permissible under any circumstances.
3. Full and accurate answers are to be elicited and recorded.
4. Please complete in block letters.

Application No:

Consultant/Broker: Medical Examiner:

Applicant's Surname: First Name(s):

Telephone Number: I.D. Number:

Residential Address:

Code:

Occupation:

1. PERSONAL STATEMENT

Has a proposal/application for life, health, dread disease, disability or functional impairment assurance ever been declined deferred or accepted with certain provisions e.g. a higher premium, or any exclusions etc? ☐ YES ☐ NO

If "yes", state full particulars ____________________

2. MEDICAL HISTORY

Do you have or have you EVER had any of the following? If "yes", state full details of each instance in the schedule following question 2.14.

		YES	NO
2.1	Disorder of the heart, e.g. rheumatic fever, heart murmur, raised cholesterol, shortness of breath, palpitations, chest pain or discomfort, or a heart attack?	☐	☐
2.2	High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps in the calves with exercise or Walking, etc?	☐	☐
2.3	Lung disorders e.g. tuberculosis, asthma, bronchitis, persistent cough or other breathing problems?	☐	☐
2.4	Disorder of the digestive system, stomach, gall bladder, pancreas or liver, e.g. stomach ulcer, recurrent indigestion or heartburn, rectal bleeding, piles or yellow jaundice or have you ever had a gastroscopy or other special examinations?	☐	☐
2.5	Disease or disorder of the kidneys, bladder or sex organs, e.g. abnormal urine test, kidney stones, prostatitis, bladder infections or sexually transmitted disease e.g. hepatitis B, gonorrhoea or syphilis etc?	☐	☐
2.6	Have you ever sought medical advice, personal counselling or treatment in connection with AIDS or HIV infections, blood, urine or saliva testing except for routine assurance tests? If "yes", please give details	☐	☐
2.7	Disorders of the nervous system e.g. epilepsy or fits, blackouts, stroke?	☐	☐
2.8	Mental disorders e.g. depression, anxiety, panic attacks or post traumatic stress disorder?	☐	☐
2.9	Ear, eye, nose or throat disorder, e.g. defective vision, hearing loss, ear discharge, hoarseness?	☐	☐
2.10	Disease or disorder of the skin, muscles, bones, joints, limbs, spine, e.g. any skin rash, rheumatism or arthritis, gout, or any back trouble?	☐	☐
2.11	Diabetes, sugar in urine, thyroid or other glandular or blood disorders, e.g. anaemia or bleeding disorders?	☐	☐
2.12	Cancer, a growth or tumor of any kind, including moles, removed?	☐	☐
2.13	If not already mentioned, have you had any other illness, including chronic fatigue (yuppie flu), tropical disease (bilharzias or malaria), or have you had any operations, disability or accidents (including motor vehicle accidents) or been hospitalised?	☐	☐
2.14	Have you been medically boarded or have you submitted claims for disability or 3rd party benefits?	☐	☐

Please note that in the event of any modification or variation of this standard form Resolution Life will regard this form as being invalid and of no force and effect.

Do not sign blank or incomplete forms.

Client's Name: | | | | | | | | | | | | | | | | | | | | | Date Of Birth: D D M M Y Y Y Y

Question No.	Nature and duration of complaint or symptoms	Date	Name and address of attending Doctor or hospital	When last did you have symptoms?

3. FOR FEMALE APPLICANTS

3.1 Have you ever had or do you now have any disorder of the female organs (breast, ovaries, uterus), or any abnormality of pregnancy or delivery, e.g. abnormal vaginal bleeding, and lumps or cysts of breasts and ovaries? If "yes", state full details including dates. ☐ YES ☐ NO

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3.2 Are you pregnant? If "yes", how many weeks? ☐☐☐☐☐☐ ☐ YES ☐ NO

3.3 Do you regularly have Pap smears or mammograms? If "yes", please provide details of the most recent result ☐ YES ☐ NO

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4. If not already stated, have you EVER:

4.1 Had any X-rays, E.C.G.'s or other examinations including genetic testing or tumor markers, operations? ☐ YES ☐ NO

4.2 Taken any medicines including anti-depressants, tranquillisers or drugs including cannabis (dagga), cocaine, ecstacy, anabolic steroids etc. for medical or other reasons? ☐ YES ☐ NO

4.3 Consulted any doctors or other practitioner's e.g. Chiropractors, homeopaths, reflexologists etc or traditional healers. ☐ YES ☐ NO

4.4 Have you ever had any check-ups, or assurance medicals? ☐ YES ☐ NO

4.5 Are you taking chronic medication for any condition? ☐ YES ☐ NO

If "yes", to any of the above, state details in schedule below:-

Exact nature of examination Consultation and treatment	Date	Name and address of Doctor, specialist or hospital	Results of examinations and date of latest symptoms

4.6 Names and addresses of any medical attendants consulted in the last 5 years

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5. WEIGHT/EXERCISE

5.1 Has your weight altered by more that 5kg over the last year?
If "yes", has it increased or decreased, by how much, for what reason? If "no", for how long has the present weight been constant? ☐ YES ☐ NO

____

5.2 Do you take regular physical exercise? If "Yes", please provide details ☐ YES ☐ NO

____

6. HABITS (NB: The company reserves the right to perform urine/blood tests for drugs or smoking).

6.1 What and how much do you smoke per day? ______________________________

6.2 If you have stopped or reduced smoking, state date of change and your previous smoking habits. ______________________________

6.3 State type and amount of alcoholic liquor consumed: ____________ per day: ________ per week: ________

6.4 Have you ever consumed more alcohol on a regular basis, or have you ever been charged with drunken driving?
If "yes", state full details including any treatment. ☐ YES ☐ NO

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7. FAMILY HISTORY

	Age if alive	If alive, give details of past or present health problems	Age at Death	If deceased give cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

Client's Name: Date Of Birth: D D M M Y Y Y Y

7.1 If not already stated, have any close blood relatives suffered from sugar diabetes, heart disease, cancer, high blood pressure, raised cholesterol, mental illness, or any other hereditary disease? If "yes", state full details. YES NO

8. Are there any activities not disclosed above which may affect the risk of assurance on yur life, e.g. hazardous pastimes, paragliding, motorbike racing,scuba diving? If "yes", state full particulars YES NO

9. Do you intend seeking medical advice in the future, for an existing medical complaint? Is any future surgery planned? YES NO

10. Have you received an HIV Vaccine as a participant in a Vaccine Trial?
If "yes", please provide the date and place as well as your unique Identity Number? YES NO

DECLARATIONS BY THE PERSON WHOSE LIFE IS TO BE ASSURED

I declare and warrant that his personal statement, whether in my handwriting or not, is complete and true and also that I understand and agree that this statement together with the proposal for assurance of my life and any other documents, shall be the basis of the proposed contract of assurance. I hereby irrevocably authorise and request any doctor, other person or institution who may be in possession of, or later obtain, any information concerning my health, to disclose such information to Resolution Life, and I agree that this request shall remain in force after my death.

Signed at ______ this ______ day of D D M M Y Y Y Y

Signature of Medical Examiner

Signature of Applicant

Please do not arrange for any examinations or report, which may involve further expenses unless so authorised by Resolution Life.

11. Build and Physical Condition (Question 11.2 is not needed in case of a female applicant)

11.1 Height (without shoes) Weight (in clothes)

11.2 Chest (insp.) (exp.) Abdomen

11.3 State your impression of the general appearance of the applicant (e.g. thin, muscular, pale, flushed, etc)

Are there:

11.4 Any operation scars of skin lesions? YES NO

11.5 Signs of hyperlipaemia, e.g. arcus senilis, Xanthoma, xanthelasma, etc? YES NO

11.6 Enlarged thyroid or lymphatic glands, breast lumps or tumors as per palpation? YES NO

11.7 Any hernia, varicose veins or piles? YES NO

11.8 Any signs of ear disease? YES NO

Describe in detail any adverse findings and state whether operative or other treatment is required.

12. Cardiovascular System

12.1 Blood pressure (to be taken in recumbent posture)
Systolic mm.Hg.
Diastolic mm.Hg.

12.2 If the blood pressure is above 140/90, record a second reading, preferably at the end of the examination.
Repeat
Systolic mm.Hg.
Diastolic mm.Hg.

12.3 State the peripheral pulse: Rate Is the Peripheral pulse readily palpable? YES NO

12.4 Are there symptoms or signs of any cardiovascular abnormality, e.g. signs of cardiac enlargement, cardiac failure, abnormal heart sounds or arrhythmia? YES NO

13. Respiratory System

13.1 Is there any indication of past or present disease? YES NO

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Describe fully any abnormality detected such as deficient air entry, abnormal character of breath sounds or adventitious sounds.

14. Gastro-Intestinal System

14.1 Is there any significant abnormality of the mouth or throat e.g. tumor or leukoplakia? YES NO

14.2 Is there any indication of disease of gastro-intestinal system, liver or spleen? YES NO

Describe fully any unhealthy condition, tenderness, palpable mass or other abnormality detected.

15. Central Nervous System

15.1 Is there any significant abnormality of the mouth or throat e.g. tumor or leukoplakia? YES NO

15.2 Describe fully any evidence of disease of the central nervous system.

16. Musculoskeletal System

16.1 Are there any signs of joint disease, arthritis, or any abnormalities of the back? YES NO

16.2 Are there any other deformities or physical abnormalities? YES NO

17. Genito-Urinary System Urine examination (specimen must be voided in surgery).

17.1 Is protein present? YES NO

17.2 Is glucose present? YES NO

17.3 Is urobilinogen present? YES NO

17.4 Is blood present? YES NO

17.5 Is there any other abnormal findings? YES NO

If present, please quantify and give name of test used.

18. General

18.1 Is the application known to your or do you have any special examinations or results of previous examinations? If "yes", please provide details and include comments on reports (these will be returned to you). YES NO

18.2 Are you aware of any factor which places the proposer at risk of infection by the HIV virus or any sexually transmitted disease? If "yes", please give details including results of any blood tests or other investigations. YES NO

18.3 Do you know or suspect any other factors regarding past or present health or habits (alcohol, tobacco, drugs etc) which may influence the assured's life expectancy or ability to follow his/her chosen occupation, or lead to a claim under a medical health plan? Please comment fully. YES NO

18.4 Would you advise any special examinations (e.g. blood tests, chest X-rays, lung function tests, cardiologist's or neurologist's opinion, etc.) to clarify any points of your examination? If "yes", which examination and why you advise it. YES NO

Please provide full details to questions answered "yes" above and provide question number.

Please Note: **In order to avoid any embarrassment, the results of this examination are not to be disclosed to the applciant or any other unauthorised person**

Please note that the proposer/life assured has authorized us to obtain this information from you (and has instructed you to provide us with this information) and to share it with other life offices directly or through the LOA for purposes of underwriting and/or other claims assessment. In terms of the LOA protocol the proposer/life assured may enquire about information held by the LOA and such information will be made available to him/her through his/her nominated medical practitioner. Please send this confidential report without delay marked private and confidential and addressed to the Chief Medical Officer at Resolution Life to the applicable address: P O Box 1555, Fountainbleau, 2032.

Client's Name: ____________________ Date Of Birth: D D M M Y Y Y Y

DECLARATION OF VERIFICATION OF THE IDENTITY OF THE APPLICANT

I, ______________________________ declare that I have taken due and proper care to verify the true identity of the applicant and have witnessed his/her signature, and I have inspected the applicant's:

- [ ] ID Number
- [ ] Passport number:
- [ ] Card-type driver's license

Signed at ______________________ this ______________ day of D D M M Y Y Y Y

To facilitate full payment please indicate whether the following have been taken and forwarded to a Laboratory:

Please tick: [ ] General Practitioner [ ] Physician Specialist

Please tick: [ ] Urine Sample [ ] Blood Sample

Name of Laboratory that samples were sent to:

Name of Branch:

I confirm that this examination has been conducted in a fully equiped surgery.

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Signature of Medical Examiner/Registered sister

Qualification:

Year of first qualifying

Telephone No:

SAMDC Registration No.:

SANC Registration No:

Practice No.:

Full Postal Address Of Medical Examiner/Nurse

Code

PAYMENTS

Note - please make all invoices payable to RESOLUTION LIFE Ltd.