

SHORT MEDICAL REPORT

MAY BE COMPLETED BY A DOCTOR, OR NURSE IN THE EMPLOY OF A DOCTOR

MASA Item No. 1.1.3 Payable to doctor's practise

- 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:	<input type="text"/>	Medical Examiner:	<input type="text"/>
Consultant/Broker:	<input type="text"/>	First Name(s):	<input type="text"/>
Applicant's Surname:	<input type="text"/>	I.D. Number:	<input type="text"/>
Telephone Number:	<input type="text"/>	Residential Address:	<input type="text"/>
Code:	<input type="text"/>	Occupation:	<input type="text"/>

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.

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|------|---|------------------------------|-----------------------------|
| 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.2 | High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps in the calves with exercise or Walking, etc? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.3 | Lung disorders e.g. tuberculosis, asthma, bronchitis, persistent cough or other breathing problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.4 | Disorder of the digestive system, stomach, gall bladder, pancreas or liver, e.g. stomach ulcer, recurrent indigestion or heart-burn, rectal bleeding, piles or yellow jaundice or have you ever had a gastroscopy or other special examinations? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.7 | Disorders of the nervous system e.g. epilepsy or fits, blackouts, stroke? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.8 | Mental disorders e.g. depression, anxiety, panic attacks or post traumatic stress disorder? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.9 | Ear, eye, nose or throat disorder, e.g. defective vision, hearing loss, ear discharge, hoarseness? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.11 | Diabetes, sugar in urine, thyroid or other glandular or blood disorders, e.g. anaemia or bleeding disorders? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.12 | Cancer, a growth or tumor of any kind, including moles, removed? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2.14 | Have you been medically boarded or have you submitted claims for disability or 3 rd party benefits? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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:

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

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

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, ecstasy, 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 and treatment	Consultation	Date	Name and address of Doctor, specialist or hospital	Results of examinations and date of latest symptoms
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4.6 Names and addresses of any medical attendants consulted in the last 5 years

5. WEIGHT/EXERCISE

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

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? YES NO
If "yes", state full details including any treatment.

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	<input type="text"/>	_____	<input type="text"/>	_____
Mother	<input type="text"/>	_____	<input type="text"/>	_____
Brother(s)	<input type="text"/>	_____	<input type="text"/>	_____
Sister(s)	<input type="text"/>	_____	<input type="text"/>	_____

Client's Name:

Date Of Birth:

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 your 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

Signature of Medical Examiner

Signature of Applicant

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

11. Build and Physical Condition

11.1 Height (without shoes) Weight (in clothes)

11.2 Chest (insp.) (exp.) Abdomen

Describe general appearance _____

12. Cardiovascular System

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

NOTE 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.

12.2 State pulse rate – at rest

12.3 Is the pulse rate regular? YES NO

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

13.1 Is protein present? YES NO

13.2 is glucose present? YES NO

13.3 Is urobilinogen present? YES NO

13.4 Is blood present? YES NO

13.5 Is there any other abnormal findings? YES NO

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

Important 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.

Signed at _____ this _____ day of

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

Please tick: General Practitioner Physician Specialist

