

Medical Examination Report – Strictly Confidential to Doctor and Underwriter

Full name	<input type="text"/>
Date of birth (dd/mm/yyyy)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Occupation	<input type="text"/>

Part 1 Client identification

Please quote the applicant's identity card number/
passport number:

These documents are the preferred proof of identity. If none of these are available you may accept the birth certificate or drivers licence.

Have you satisfied yourself as to the identity of the client? Yes ☐ No ☐

IF THE APPLICANT IS UNABLE TO PROVIDE SATISFACTORY IDENTIFICATION, PLEASE DO NOT PROCEED.

Part 2 Statement of personal and medical history – to be made by the examinee

Where necessary, questions should be enlarged upon by the examiner. If answering Yes to any of the questions, please give full details including dates and particulars.

1. Have you ever suffered from any of the following:

a) Bronchitis, asthma, respiratory or lung condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please give details below.
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
b) Anxiety, depression, nervous breakdown or any other nervous or mental disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please give details below.
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
c) Angina, heart attack, hypertension, rheumatic fever, heart murmur, circulatory disease or any other heart disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please give details below.
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
d) Stomach, bowel, liver or gall bladder disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please give details below.
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			

2. a) Have you ever undergone any surgical operations, x-rays investigations or blood tests? Yes ☐ No ☐ If Yes, please give details below.

b) Are you receiving any form of medical treatment including prescribed medicine or drugs? Yes ☐ No ☐ If Yes, please give details below.

c) Have you ever received treatment for high blood pressure? Yes ☐ No ☐ If Yes, please give details below.

3. a) Have you ever had an AIDS blood test? Yes ☐ No ☐ If Yes, please give details below.

b) Have you ever received medical advice, counselling or treatment in connection with AIDS or HIV or any other sexually transmitted disease including Hepatitis B? Yes ☐ No ☐ If Yes, please give details below.

4. Have you ever taken drugs other than for medical purposes? Yes ☐ No ☐ If Yes, please give details below.

5. a) How much alcohol do you consume weekly and in what form? Please note that "N/A", "-" and "/" are not acceptable answers.

Beer (litres)	<input style="width: 60px;" type="text"/>
Wine (75cl bottles)	<input style="width: 60px;" type="text"/>
Spirits (measures)	<input style="width: 60px;" type="text"/>

b) How much tobacco do you use daily and in what form?

Cigarettes	<input style="width: 60px;" type="text"/>
Cigars	<input style="width: 60px;" type="text"/>
Gms of tobacco	<input style="width: 60px;" type="text"/>

c) Has either of these habits differed significantly in the past? Yes ☐ No ☐ If Yes, please give details below.

d) Has any insurer ever declined, postponed or accepted an application on your life on special terms, or have you withdrawn an application? Yes ☐ No ☐ If Yes, please give details below.

6. Does/has any member of your immediate family:

a) Suffer/ed from cancer, diabetes, stroke, kidney disease, multiple sclerosis, heart disease, high blood pressure?

Yes ☐ No ☐

b) Suffer/ed from any hereditary disease?

Yes ☐ No ☐

c) Died before the age of 65?

Yes ☐ No ☐

Please complete the following section.

Family member	If living		If dead	
	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

Declaration

Data Protection Act

Any data you provide to RL360° may be shared, if allowed by law, with other companies both inside and outside of the RL360° Group and to persons who act on your behalf. Data and information about you can be transferred outside of the Isle of Man and RL360° may be required to provide it to its regulator, its government or anyone else required by law.

RL360° will use your data and information to allow for the administration of your policy, prevent crime, prosecute criminals and for market research and statistics. RL360° will, at all times, make sure that your data and information is only used in ways that are allowed by law.

The Isle of Man Data Protection Act 2002 allows you, after paying a small fee, to receive a copy of the data and information RL360° holds about you.

For further information please write to: Data Protection Officer, RL360°, RL360 House, Cooil Road, Douglas, Isle of Man, IM2 2SP, British Isles.

To be signed by the person who is being examined.

I declare that the aforementioned statements are true and correct to the best of my knowledge and belief and I agree that they shall form part of my application for life assurance.

Signature of examinee

Date (dd/mm/yyyy)

Part 3 Medical examination

Answers to be given by the doctor. Please give full details where appropriate.

Measurements (stripped to underclothing)

Height Feet Inches Centimetres

Weight Pounds Kilograms

Chest:

Inspiration Inches Centimetres

Expiration Inches Centimetres

Abdomen Inches Centimetres

1. General

- a) To your knowledge is the weight (please tick as appropriate) Stationary ☐ Increasing ☐ Diminishing ☐

Please provide additional information where appropriate

- b) Describe the general appearance and build

- c) Does the appearance correspond with the stated age?

Yes ☐ No ☐ If No, please give full details including dates and particulars.

- d) Are there any signs of physical abnormalities or previous operations or trauma (e.g. scarring)?

Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- e) Is there any evidence of excessive habits?

Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

2. Lungs

- a) Is the chest well developed and does it expand freely? Yes ☐ No ☐ If No, please give full details including dates and particulars.

- b) Are there any abnormal physical signs? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- c) Are the breath sounds normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.

3. Heart

- a) Is the position of the apex beat normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.
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- b) Is it unduly forceful? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.
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- c) Is the heart enlarged? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.
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- d) Is there any abnormality of the heart sounds or any murmurs present? If any murmur found, please describe the murmur and state, whether considered functional or organic in origin, and give reasons. Yes ☐ No ☐ If Yes, please give full details including dates and particulars.
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- e) Is the heart rhythm normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.
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4. Pulse

- a) Measure the rate and describe the character.
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- b) What is the state of the arterial walls?
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- c) Is there any vascular abnormality in the legs or reduced foot pulses? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.
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5. Blood pressure

If the first reading exceeds 140 systolic or 90 diastolic (5th phase), please take 2nd and 3rd readings at 5 minute intervals.

	1st reading	2nd reading	3rd reading
Systolic			
Diastolic (5th phase)			
Pulse			

6. Nervous system

- a) Are the pupil reactions normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.

- b) Are the knee and ankle reflexes and gait normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.

- c) Are speech, memory and sight normal? Yes ☐ No ☐ If No, please give full details including dates and particulars.

- d) Is there evidence of an ear disorder or is the hearing impaired? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- e) Is there evidence of any disease of the central nervous system? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

7. Abdomen

- a) Is there any evidence of past or present digestive trouble, or disorder of:
- i) the liver? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- ii) the spleen? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- iii) the stomach? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- iv) the bowels? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

- b) Is there a hernia present? Yes ☐ No ☐ If Yes, please give full details including dates and particulars.

8. Urine

If any abnormality is discovered and the life proposed presents no other evidence of renal disease, it would be helpful if he/she is asked to call again and bring two specimens of his/her urine - one passed at night on retiring and the other passed on rising in the morning. The result of the test in each case should be recorded separately.

- a) Is albumin present? Yes ☐ No ☐
- b) Is sugar present? Yes ☐ No ☐
- c) Is blood present? Yes ☐ No ☐
- d) Any other abnormalities? Yes ☐ No ☐

9. Additional information

Please elaborate on any relevant answers given by the examinee and/or any abnormal findings which are significant. Please attach additional sheets if necessary.

[illegible]

RL360's medical
examiner's reference
number

Medical Attendant's full
name (please print)

Qualifications

Signature

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Date (dd/mm/yyyy)

[illegible]