F.N-003-1902

NEPALLIFE INSURANCE CO. LTD.

Registered Office: Main Road, Birgunj (Parsa)
Head Office: P.O.Box :11030, Heritage Plaza, Kamaladi, Kathmandu

MEDICAL EXAMINER'S REPORT

Branch: .....

STATEMENT TO MEDICAL EXAMINER

Proposal No.: .....

Full name of proposed life :	Citizenship/PP No.	Male ☐ Female ☐	Date of Birth:	Age:	Name of agent code No :
Occupation :	Amount of insurance applied for now: Existing insurance:		Name & Address of your personal doctor or doctor that you frequent most.		Are you on any form of medication at present? Yes ☐ No ☐ If YES state reason and type of medication.
Date of last consultation: Reasons for this consultation: Name of doctor consulted:					

Have you at ANYTIME consulted a PSYCHIATRIST? If Yes, give details and dates

Yes ☐ No ☐

DETAILS of 'Yes' answers. (IDENTIFY QUESTION NUMBER CIRCLE APPLICABLE ITEMS. Include diagnosis, dates, results, duration, names and addresses of all attending doctors and medical facilities).

1. Have you EVER had or been told you had or been treated for:	Yes	No
a) Epilepsy, fainting spells, seizure, nervous or mental condition, neuritis, paralysis or any disease or abnormality of the brain or nervous system?	☐	☐
b) Giddiness, loss of consciousness, breathlessness, chest pain, high blood pressure, palpitation or any disease of the heart, blood or blood vessel?	☐	☐
c) Blood spitting, tuberculosis, asthma, habitual cough, pleurisy, or any respiratory or lung disease?	☐	☐
d) Recurrent indigestion, ulcer, hernia or disease of liver, gall-bladder, stomach or intestine?	☐	☐
e) Urinary sugar/albumin/stones, venereal disease, menstrual disorders, or diseases of the kidney, prostate, urinary or genital system?	☐	☐
f) Diabetes, goiter or any disease or abnormality of the thyroid or other endocrine glands?	☐	☐
g) Diseases of eyes, ears, nose (including nose bleeds) or throat?	☐	☐
h) Cancer, tumor, cyst or any growth?	☐	☐
i) Jaundice, hepatitis, any disease of the liver or been a hepatitis carrier?	☐	☐
j) Malaria, dysentery or any tropical diseases?	☐	☐
k) Rheumatic fever, arthritis, gout or any disease of the spine, prolapsed intervertebral disc, bone, joint, muscle, connective tissue, lymph nodes or any diseases of the skin.	☐	☐

2.Have you ever:

Received any medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition; or been told you had any of these; OR have you had HIV testing done (please state result), OR in the last 3 months had any of the following symptoms for more than one week continuously fatigue, weight loss or diarrhea.

	Yes	No	DETAILS of 'Yes' answers. (IDENTIFY QUESTION NUMBER CIRCLE APPLICABLE ITEMS. Include diagnosis, dates, results, duration, names and addresses of all attending doctors and medical facilities).
3. In the PAST 5 YEARS, have you had any			
a) Diagnostic tests such as X-ray, mammography, biopsy, Pap smear, electrocardiogram, CT scanning, echo or ultrasound, blood or urine studies, or any other investigations?	☐	☐	
b) Illness, injury, operation, medical advice, hospital treatment or physical check-up not mentioned above ?	☐	☐	
4.a) Do you smoke			
If so, in what form, quantity and duration?	☐	☐	
b) Do you drink beer, wine or spirits? If so, in what form and quantity?	☐	☐	
c) Have you at any time been in the habit of drinking more heavily than you do now? (If so, please give details)?	☐	☐	
d) Have you ever used habit forming drugs or narcotics, or been treated for alcoholism or drug habit?	☐	☐	
e) Do you have other physical defects or health impairments?	☐	☐	
5.a) To the best of your knowledge and belief, has any of your immediate family members ever had or died from cancer, tuberculosis, diabetes, heart disease, hypertension, mental disease, kidney disease or any other hereditary disease.....	☐	☐	
b) Have you suffered from any AIDS related condition or been tested HIV Positive ?	☐	☐	

6. Family Record	Age if living	Cause of Death	Age at Death
Father			
Mother			
Brother			
Sister			

7. a) Has your weight changed more than 5kg in the past year, if so why?	☐	☐
b) Has any application for insurance on your life ever been declined, withdrawn, postponed, rated or modified in any way?	☐	☐
8. FEMALE ONLY		
a) Have you ever had any disease of the breast, cervix uteri, uterus, ovaries including breast lump, ovarian cyst, carcinoma in situ, fibroid, polyp, abnormal menstrual bleeding or post coital bleeding?	☐	☐
b) Have you ever had complications at child-birth such as gestational diabetes, gestational hypertension, miscarriage, stillbirth, ectopic pregnancy?	☐	☐
c) Are you now pregnant? If so, please provide gestational period and expected delivery date?	☐	☐

DECLARATION & CONSENT

I/life to be assured declare that the answer to the above questions are true and complete and that I/ lifeto be assured have not withheld or concealed any circumstances on which information is required toassess the risk of an assurance on my/life to be assured life.I/life to be assured agree that this personal medical statement together with my answer to the question on the separate proposal form for life assurance shall be the basis of the contract between me/life to beassured and Nepal Life Insurance Co. Ltd.

Date :

.....

Signature of the Medical Examiner:

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Name: :.....

Signature of the life to be assured:

.....

Name:.....

MEDICAL EXAMINERS CONFIDENTIAL REPORT
THIS EXAMINATION SHOULD BE MADE IN PRIVATE. NO THIRD PERSON SHOULD BE PRESENT

	Yes	No	DETAILS – PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS AND OPINIONS
9. Have you ever seen the proposed life professionally before? If "yes", we would appreciate if you would review your records to confirm that all items of the proposed life's physical history have been declared overleaf. If not, please give details on any omissions or inaccuracies.	☐	☐	
10. Are you in any way related to the proposed life or to the agent?	☐	☐	
11. a) Is there any evidence of ulcers, hernia, piles, fistula or varicose veins?			
b) Does appearance indicate poor health?	☐	☐	
c) Does he/she appear older than stated age?	☐	☐	

Height (cm)	Weight (kg)	Chest (cm) (force expiration)	Chest (cm) (force inspiration)

Visual acuity:	uncorrected	corrected
Left Eye Right Eye		

12. Do you find any evidence of past or present disease or abnormality of:-

a) Respiratory system (lungs, pleura, chest wall)?	☐	☐
b) Central or peripheral nervous system (including reflexes, gait, paralysis)?		
c) Genito-urinary system?	☐	☐
d) Gastrointestinal system?	☐	☐
e) Skin, bones or joints (including varicose veins, deformities, lameness, amputations, scars / identifying marks)?	☐	☐
f) Eyes, ears, nose, throat and mouth (including impairment of sight or hearing)?	☐	☐
g) Thyroid or other endocrine glands or metabolic and haemopoietic systems?	☐	☐
h) Lymphatic System.....	☐	☐
i) Breasts.....	☐	☐

13. a)	**URINALYSIS** N.B. "Trace" Amount must be noted.	**Blood**	**Sugar**	**Albumin**	**Specific gravity**

Send specimen for microscopic urinalysis if:

a) Blood pressure is over 140/90

b) Albumin, blood or sugar is present

c) There are any findings or history of urinary disease

d) Applicant is a diabetic or under treatment for blood pressure

e) Family history of diabetes

• If blood detected in female clients – kindly indicate L.M.P.

Is blood specimen sent for analysis? Yes ☐ No ☐ If Yes, which profile?

DETAILS – PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS AND OPINIONS

14. BLOOD PRESSURE (if over 140 systolic or 90 diastolic or with history of hypertension, record 3 readings)

Systolic	mmHg	mmHg	mmHg
Diastolic (5th phase)	mmHg	mmHg	mmHg

15. PULSE At Rest

Rate Per Minute	
Irregularities Per Minute	

	Yes	No	DETAILS – PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS AND OPINIONS
16. HEART : Apex beat located in ..... intercostal space ..... cm to the R ☐ L ☐ of the MIDSTERNAL line.			
Is the heart enlarged?	☐	☐	
Is there any:			
a) Arteriosclerosis or aneurysm?	☐	☐	
b) Hypertrophy or oedema?	☐	☐	
c) Murmur (if murmur is present, describe below)	☐	☐	

Location: ☐ Parasternal ☐ Apex ☐ Aortic area ☐ Base ☐ Pulmonary area

Timing: ☐ Systolic ☐ Diastolic ☐ Presystolic ☐ Pansystolic

Intensity: ☐ Soft ☐ Moderate ☐ Loud

Transmission: ☐ None ☐ Axilia ☐ Scapula

After exercise: ☐ Absent ☐ Decreased ☐ Unchanged ☐ Increased

Diagnosis .....

Is there excessive dyspnea after exercise?	☐	☐
17. Do you suspect any abnormality in the heart or vascular system upon review of your overall findings?	☐	☐
18. Do you have any reason to believe that the proposed insured is a higher that average risk for AIDS? If so, why?	☐	☐
19. a) Are you aware of any unfavourable features likely to affect his / her longevity		
i. in the personal or family history?	☐	☐
ii. disclosed by your medical examination?	☐	☐
b) Do you recommend any additional tests or reports?	☐	☐
c) Do you know any facts about this risk not brought up earlier?	☐	☐

d) What is your general impression of the patient after completing your medical examination?

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DECLARATION

I certify that I have personally verified the identity of the applicant whom I have examined. This examination has been conducted in private at ..... on this .....day of.....20 ..... at .....am/pm.

Name of Examiner..... .....
Signature

Examiner's Code No.: .....

NRIC No.: ....
Clinic rubber stamp

DOCTOR-PLEASE CHECK YOUR REPORT FOR OMISSIONS(APS)