LONPAC INSURANCE BHD 199401021735 (307414-T)
Head Office: LG, 6th, 7th, 21st to 26th Floor, Bangunan Public Bank, 6, Jalan Sultan Sulaiman, 50000 Kuala Lumpur, Malaysia.
P.O. Box 10708, 50722 Kuala Lumpur, Malaysia.
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MEDICAL EXAMINER'S REPORT

Note:
- Required for Person to be Insured aged (next birthday) between 60 to 70 years when first apply for insurance.
- Cost in obtaining the Medical Examiner's Report is to be borne by the Person to be Insured regardless of the underwriting decision.

PART 1: STATEMENT TO THE MEDICAL EXAMINER

Full Name of Person to be Insured (as shown in NRIC) : _____

New NRIC/Passport Number : _____

Date of Birth (dd/mm/yyyy) : _____ Height (in cm) : _____ Weight (in kg) : _____

Name and address of your personal doctor or doctor that you frequent most. If none, the doctor that you last visited:

_____

Date, reason, name and address of doctor that you last consulted:

Date: _____ Reason: _____

Doctor's Name and Address :_____

	HEALTH DETAILS	Yes	No	Details of "Yes" answers (Identify question number and circle applicable items: Include diagnosis, dates, duration, names and address of all attending doctors and medical facilities)
1.	Are you on any form of medication at present? If yes, please provide reason and type of medication and name of doctor consulted.	☐	☐	
2.	Have you at ANYTIME consulted a PSYCHIATRIST?	☐	☐	
3.	Have you EVER received any medical advice, counseling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition; or been told you had any of these; OR that you had HIV testing done (please state date and result), OR in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐	☐	
4.	Have you EVER had or been told you had or been treated for: (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?	☐	☐	

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	(c) Blood spitting, tuberculosis, asthma, habitual cough, pleurisy, or any respiratory or lung disease?	☐ ☐	
	(d) Recurrent indigestion, ulcer, hernia or disease of liver, gallbladder, stomach or intestine?	☐ ☐	
	(e) Urinary sugar / albumin / stones, venereal disease, 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, tumour, 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 disease of the skin?	☐ ☐	
5.	In the **PAST 5 YEARS**, have you had any:		
	(a) Diagnostic tests such as X-ray, mammography, electrocardiogram, CT scanning, echo or ultrasonogram, blood or urine studies?	☐ ☐	
	(b) Illness, injury, operation, medical advice, hospital treatment or physical check-up not mentioned above?	☐ ☐	
6.	(a) Do you smoke? If yes, in what form, quantity and duration?	☐ ☐	
	(b) Do you drink beer, wine or spirits? If yes, in what form and quantity?	☐ ☐	
	(c) Have you at any time been in the habit of drinking more heavily than you do now? (if yes, 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 any other physical defects or health impairments?	☐ ☐	
7.	(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) Has your spouse suffered from any AIDS related condition or been tested HIV positive?	☐ ☐	

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8.	Family Record: Father / Mother — Age if living / Cause of death / Age at death		
9.	(a) Has your weight changed more than 5 kg in the past year? If yes, please state reason. (b) Has any application for insurance on your life ever been declined, withdrawn, postponed, rated or in any way modified by an insurance company?	☐ ☐ ☐ ☐	
10.	**FOR FEMALE ONLY:** (a) Have you ever had any disease or disorder of the breast or female reproductive organ, menstrual disorder, abnormal pap-smear test, or complications at child birth? (b) Are you now pregnant? If so, how many months?	☐ ☐ ☐ ☐	

DECLARATION AND CONSENT

I the undersigned, hereby confirm that the above answers, given by me, are full, complete and true and agree that they form part of any policy, where these answers are or may be, relied upon by the Company.

Having read and understood the contents hereof, I also hereby authorise any of the Company's appointed medical examiners or designated laboratories to conduct or perform blood and / or urine tests, as may be necessary to underwrite my application for insurance coverage. These may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, infection by the AIDS virus, immune disorders or the presence of medication, drugs, nicotine or their metabolites.

Provided that, unless my prior consent has been obtained, the Company shall, at all times, keep all results of any such tests confidential and the use thereof shall only be for the purpose of my application or further applications for insurance with the Company except to such an extent that disclosure is required by any proper Government Authority or by Law, and further provided that the Company shall use all care in carrying out any such test, but shall not be liable for any unforeseen occurrence, act or omission, unless the Company has been negligent.

I hereby further authorise any physician, hospital, clinic, insurance company or other organisation, institution or person, that has any records or knowledge of me or my health, to disclose to the Company or its representative any and all information about me with reference to my health and medical history and any hospitalisation, advice, treatment, disease or ailment. A photostat copy of this authorisation shall be as effective and valid as the original.

Date at: _____ on: _____

Witnessed by: _____ _____
Medical Examiner Signature of Person to be Insured

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PART 2: MEDICAL EXAMINER'S REPORT

THIS EXAMINATION SHOULD BE MADE IN PRIVATE. NO UNAUTHORISED PERSON SHOULD BE PRESENT.

HEALTH DETAILS		**Yes**	**No**	**Details – Please give full details of adverse findings and opinions (Identify item)**
1.	Have you ever seen the Person to be Insured professionally before? If YES, we would appreciate if you could review your records to confirm that all items of the Person to be Insured physical history have been declared overleaf. If not, please give details of any omissions or inaccuracies.	☐	☐	
2.	Are you in any way related to the Person to be Insured?	☐	☐	
3.	(a) Is there any evidence of ulcers, hernia, piles, fistula or varicose veins? (b) Does the appearance of the Person to be Insured indicate poor health? (c) Does the Person to be Insured appear older than the stated age? **FOR MALE ONLY:** Chest (cm)(force expiration) / Chest (cm)(force inspiration) **Visual Acuity** / **Uncorrected** / **Corrected** Right eye Left eye	☐ ☐ ☐	☐ ☐ ☐	
4.	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, amputation, scars/identifying marks)? (f) Eyes, ears, nose, throat and mouth (including impairment of sight or hearing)? (g) Thyroid or other endocrine glands or metabolism and haemopoietic systems?	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	

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	(h) Lymphatic system?	☐ ☐	
	(i) Breast?	☐ ☐	

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

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

6. **PULSE**

	At rest	*Immediate After exercise	*3 minutes after exercise
Rate per unit			
Irregularities per minute			

* Note: Exercise is only required if pulse is irregular

7.	**HEART**: Apex beat located in _____ intercostal space _____ cm to the ☐ Right ☐ Left of the MIDSTERNAL line.		
		Yes No	
	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 ☐ axilla ☐ scapula

After exercise ☐ absent ☐ decreased ☐ unchanged ☐ increased

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	Diagnosis: _____ Is there excessive dyspnea after exercise?	☐ ☐	
8.	Do you suspect any abnormality in the heart or vascular system upon review of your overall findings?	☐ ☐	
9.	Do you have any reason to believe that the Person to be Insured is a higher than average risk for AIDS? If yes, why?	☐ ☐	
10.	(a) Are you aware of any unfavorable features likely to affect the Person to be Insured 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 Person to be Insured after completing your medical examination? _____ _____ _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

DECLARATION

I certify that I have personally verified the identity of the Person to be Insured whom I have examined.

This examination has been conducted in private at _____

on this _____ day of _____ at _____ am/pm

Name of Examiner: _____

_____
Signature of Examiner

_____
Clinic Rubber Stamp