MEDICAL EXAMINATION FORM

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and for what premium.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

If your application to vary your Policy is accepted, the Policy will be treated as a consumer insurance contract to the extent of the variation.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If the duty is not met

If the duty is not met, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

You are responsible for the information provided to us when applying for insurance. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask you whether the answers to the questions that you have given when applying for insurance remain accurate or whether there has been a change to any of your circumstances. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you have difficulty understanding the process of applying for life insurance or answering our questions.

If you're having difficulty due to a disability, language, or for any other reason, please let us know - we're here to help and can provide additional support.

Part 1 – Personal statement by the person to be insured

Made in connection with an application for Insurance on the life of:

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Please specify

Surname

Given name(s)

Date of birth / / Occupation

Postal address

State Postcode

Name of Adviser authorising examination

Type of insurance being applied for (tick appropriate box)

☐ Life Cover ☐ TPD Stand Alone Cover ☐ Trauma Cover

☐ Income protection/Business Expenses Cover ☐ Group Insurance products

In your own words please complete prior to the examination

- Questions 1 to 3 of the Medical history
- Family history, Lifestyle and Doctor's details
- Any relevant and Special health questionnaire(s).

The medical examiner will discuss your answers with you and add any details considered appropriate.

PLEASE SIGN THE DECLARATION IN THE MEDICAL EXAMINER'S PRESENCE.

This information is collected to assist TAL Life Limited in deciding whether to insure you now or in the future. This information may be disclosed to your adviser, your doctor, or any other doctor requested to examine you by TAL Life Limited.

The medical examiner is requested to ensure that a clear and complete answer is given to each of the following questions.

Medical history

1. What is your height and weight? ..... Height cm Weight kgs
2. Are you left handed or right handed? ..... Left ☐ Right ☐
3. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
   a. Heart attack, heart murmur, angina, chest pain, stroke, hypertension (high blood pressure), high cholesterol or any other heart or blood vessel disorder? ..... Yes ☐ No ☐
   b. Asthma, bronchitis, emphysema, tuberculosis or any other lung or respiratory disorder or sleep apnoea or any sleeping disorder? ..... Yes ☐ No ☐
   c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder? ..... Yes ☐ No ☐
   d. Recurrent indigestion, hernia, ulcer, passing of blood from the bowel, vomiting of blood, hepatitis (A,B,C or D), or any other disorder of the liver, gall bladder, intestines, stomach or pancreas? ..... Yes ☐ No ☐
   e. Cancer, tumour, skin cancer, skin spot, mole, lump or growth of any kind, or breast lumps (even if you have not seen a doctor)? ..... Yes ☐ No ☐
   f. Epilepsy, fainting attacks, fits of any kind, paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? ..... Yes ☐ No ☐
   g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (this does not include long or short sightedness corrected by glasses or contact lenses) ..... Yes ☐ No ☐
   h. Back pain, or neck pain, strain, sciatica, disorder of the spine or neck, or any disorder of the joints, muscles, ligaments, cartilage or limbs? ..... Yes ☐ No ☐
   i. Arthritis, gout, osteoporosis, fibromyalgia, tendonitis, tenosynovitis, Repetitive Strain Injury (RSI) or any inflammatory disorder, regional pain syndrome or chronic fatigue? ..... Yes ☐ No ☐
   j. Diabetes, abnormal blood sugar, thyroid disorder or any other glandular disorder? ..... Yes ☐ No ☐
   k. Psoriasis, eczema or any other disorder or cancer of the skin, or any allergic or chemical sensitivity reaction? ..... Yes ☐ No ☐

If you answered 'yes' to any of the conditions above, please also complete a special health questionnaire (on pages 4 to 7) for each condition.

   l. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? ..... Yes ☐ No ☐
   m. Sexually transmitted disease, renal colic or stone, blood in the urine or any disorder of the kidneys, bladder, prostate or reproductive organs? ..... Yes ☐ No ☐
   n. Any other sickness, injury, physical impairment, procedure or syndrome not previously mentioned? ..... Yes ☐ No ☐
   o. Do you take any medication on a regular basis (other than the contraceptive pill)? ..... Yes ☐ No ☐

You are only required to answer Question p. if your total sum insured including existing cover that you may have as well as cover for which you are currently applying exceed the following amounts:

- $500,000 of lump sum death cover or
- $500,000 of total and permanent disability cover (TPD) or
- $200,000 of trauma and/or critical illness cover or
- $4,000 per month in total of any combination of income protection cover, salary continuance or business expense cover.

   p. Have you ever had or are you considering having a genetic test where you received, are currently awaiting, or will receive an individual result? ..... Yes ☐ No ☐
   q. Other than already stated, in the last 3 years, have you consulted a health professional (e.g. a doctor, chiropractor, physiotherapist, osteopath, clinic) for any reason other than a common cold/flu? ..... Yes ☐ No ☐
   r. Are you considering consulting a doctor or health professional, seeking any medical examination, advice, treatment, tests or an operation? ..... Yes ☐ No ☐

If you have answered 'yes' to questions l - r, please provide full details below.

Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

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Question no. ☐ Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Females only

s. Have you ever had an **abnormal** pap smear? Yes ☐ No ☐

t. Have you ever had an abnormal breast ultrasound or mammogram? Yes ☐ No ☐

If you have answered 'yes' to question s or t above, please provide details below.

Please provide details of the test, results and dates.

/ /

Have you had any follow up tests since the initial test listed above? Yes ☐ No ☐

If 'yes', please provide details of the follow up tests, results and dates.

u. Are you currently pregnant? Yes ☐ No ☐

v. If 'yes', due date. / /

w. Have there been any complications? Yes ☐ No ☐

If 'yes', please provide details.

Family history

1. Have any of your parents and/or siblings ever been diagnosed with any of the following conditions:
   a. High blood pressure or high cholesterol ..... Yes ☐ No ☐
   b. Angina, heart attack or heart disease ..... Yes ☐ No ☐
   c. Stroke ..... Yes ☐ No ☐
   d. Diabetes ..... Yes ☐ No ☐
   e. Bowel or colon cancer, familial adenomatous polyposis or other hereditary bowel disorder ..... Yes ☐ No ☐
   f. Breast cancer and/or ovarian cancer ..... Yes ☐ No ☐
   g. Prostate cancer ..... Yes ☐ No ☐
   h. Any other type of cancer (other than stated above) ..... Yes ☐ No ☐
   i. Muscular dystrophy, Parkinson's Diseases or Alzheimer's disease ..... Yes ☐ No ☐
   j. Haemochromatosis, Multiple Sclerosis (MS), Huntington's Disease (Huntington's Chorea), Polycystic Kidney Disease, Motor Neurone Disease and/or any other hereditary disorder? ..... Yes ☐ No ☐

If 'yes', please provide details in the following table.

Family member (relationship to you)	Condition/sickness (for diabetes, cancer or heart disease and specify type of diabetes)	Age at onset (approx)

Note: You are only required to disclose family history information pertaining to first degree blood family members – living or deceased (mother, father, sisters or brothers).

Lifestyle

1. Have you ever smoked tobacco or any other substance? ..... Yes ☐ No ☐

   If 'yes', type e.g. cigarettes, cigars? _____ Daily quantity? _____

   How many years? _____ Date ceased? / / if applicable

   Other _____

2. Do you drink alcohol? ..... Yes ☐ No ☐

   If 'yes', please advise number of standard drinks per week? .....
   Standard drink = 1 nip spirits, 1 wine glass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? ..... Yes ☐ No ☐
4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol? ..... Yes ☐ No ☐

If you answered 'yes' to questions 3 or 4, please provide details in the following table.

Question no.	Date from	Date to	Type of usage (alcohol, heroin etc.)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		

5. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) or been told you have Acquired Immunodeficiency Syndrome (AIDS)? ..... Yes ☐ No ☐
6. In the last two years, have you engaged in any activity that may have exposed you to HIV? (For example: unprotected sex, sex with a sex worker, needle stick injury, intravenous drug use, etc.) ..... Yes ☐ No ☐

If you have answered 'yes' to any part of questions 5-6, you will be contacted for further information

Doctor's details

If you do not have a regular doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your regular doctor

   Address

   Suburb State Postcode

   Phone Work ( ) Fax ( )

2. How long have you been a patient of this doctor or clinic? Date of last consultation / /

   Reason and outcome of last consultation

3. If you have been attending your current doctor for less than 2 years, please provide the following details:

   Name of previous doctor/medical centre

   Address

   Please provide date, reason and outcome of last consultation(s) / /

Special health questionnaires

Asthma

1. Date asthma first diagnosed. / /
2. How often do you experience symptoms?
   e.g. wheezing, breathlessness, chest tightness.
3. When did you last experience symptoms? / /
4. Are you woken during the night with symptoms?
   Yes ☐ No ☐ If 'yes', how often and date of last occurrence.
5. Have you ever been off work due to your asthma?
   Yes ☐ No ☐ If 'yes', please advise when and for how long.
6. What is your current treatment? Include type of medication and dosage.
7. Have you ever required use of oral steroids?
   Yes ☐ No ☐ If 'yes', please advise when and for how long.
8. Have you ever been in hospital or received emergency treatment for asthma?
   Yes ☐ No ☐ If 'yes', please advise when, for how long and where.
9. Do you ever measure your peak flow?
   Yes ☐ No ☐ If 'yes', please advise your highest and lowest readings in the past 6 months.
10. Have you ever consulted a specialist for this condition?
    Yes ☐ No ☐ If 'yes', please advise name and address of doctor and date of last consultation.
11. Does your regular doctor have details of this condition?
    Yes ☐ No ☐ If 'no', please provide name and address of doctor who has full details.
12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Anxiety/Depression/Nervous disorder

1. Nature of condition and underlying cause.
2. Describe your symptoms.
3. Date symptoms commenced. / /
   a. Are you still experiencing symptoms? Yes ☐ No ☐
   b. If 'no', when did you last experience symptoms? / /
4. Have you had any recurrence of this condition?
   Yes ☐ No ☐ If 'yes', please advise when and how many times.
5. Have you taken regular or occasional medication for this condition?
   Yes ☐ No ☐ If 'yes', please advise type, dosage and frequency.
6. Are you still taking this medication? Yes ☐ No ☐
   If 'no', please advise date ceased. / /
7. Have you had any other treatment (e.g. counselling, hospitalisation, ECT)?
   Yes ☐ No ☐ If 'yes', please advise type, dates, hospital and name and address of treating doctor.
8. Have you ever been off work or had your normal daily activities restricted in any way due to this condition?
   Yes ☐ No ☐ If 'yes', please advise when and for how long.
9. Have you any ongoing effects or restriction in your activities of any kind?
   Yes ☐ No ☐ If 'yes', please provide details.
10. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist?
    Yes ☐ No ☐ If 'yes', please advise dates and name and address of all persons consulted.
11. Please provide details of your most recent visit for this condition. Include date, name and address of the doctor or health professional consulted.
12. Does your regular doctor have details of this condition?
    Yes ☐ No ☐ If 'no', please provide name and address of doctor who has full details.

Special health questionnaires

Back/Neck

1. Area of spine affected? Neck, upper or lower back?

2. Date of first symptoms / /

3. What was the cause?

4. Have you had any diagnostic investigations e.g. CT Scans, x-rays etc?
   Yes ☐ No ☐ If 'yes', please provide details of test(s), result(s) and date(s).

5. Are you still experiencing symptoms? Yes ☐ No ☐
   If 'no', please provide date of last experienced symptoms? / /

6. How often do/did you have symptoms?

7. Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs?
   Yes ☐ No ☐

8. Have you ever been off work due to your spinal symptoms or unable to perform your normal day to day activities?
   Yes ☐ No ☐ If 'yes', when and for how long?

9. What is the nature of the treatment (e.g. spinal manipulation, deep tissue massage etc.)?

   a. Are you still receiving treatment? Yes ☐ No ☐

   b. If 'no', when did you cease treatment? / /

10. Have you ever consulted a specialist for this condition?
    Yes ☐ No ☐ If 'yes', provide name and address of specialist and date of last consultation.

11. Please provide details of your most recent visit to any other doctor or therapist for this condition. Include date, name and address of doctor or therapist consulted.

12. Have you had any ongoing effects of any kind (e.g. pain, discomfort or limitations of movement etc)?
    Yes ☐ No ☐ If 'yes', please provide details.

13. Is it necessary to avoid lifting or to restrict your daily activities in any way?
    Yes ☐ No ☐ If 'yes', please provide details.

14. Does your regular doctor have details of this condition?
    Yes ☐ No ☐ If 'no', please provide name and address of doctor who has full details.

Any other condition

1. Name of condition (exact diagnosis)

2. The cause

3. a. Describe symptoms

   b. Date symptoms commenced / /

   Date symptoms ceased / /

   c. How often do/did you have symptoms?

4. Have you ever been off work or had your normal daily activities restricted in any way because of this condition?
   Yes ☐ No ☐

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		

5. Have you any residual, on-going effects or restriction in your daily activities?
   Yes ☐ No ☐ If 'yes', please provide details.

6. Have you taken regular or occasional medication for this condition?
   Yes ☐ No ☐ If 'yes', please advise names of medication(s), dosage(s) and frequency.

   Are you still taking this medication? Yes ☐ No ☐

7. Have you had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)? Yes ☐ No ☐

8. Have you had any diagnostic investigations (e.g. scope, scan, x-rays, EEG, ECG etc)? Yes ☐ No ☐

9. Have you ever been in hospital or received emergency treatment for anything related to this condition? Yes ☐ No ☐

10. If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.

11. Details of your most recent visit to a doctor or other therapist for anything related to this condition.

Date	Reason for consultation, investigations, findings, advice
/ /	
Doctor/Therapist name and specialty	

12. Has further treatment been recommended for this condition?
    Yes ☐ No ☐ If 'yes', please provide details.

13. Does your regular doctor have details of this condition?
    Yes ☐ No ☐ If 'no', please provide name and address of doctor who has full details.

Special health questionnaires

Skin Lesion/Skin Cancer/Sun Spot

1. How many skin lesions, skin cancers or sun spots have you had treated?
2. Please provide details of each of the above in the table below. If more than 3, provide details on a separate page.

	Lesion 1	Lesion 2	Lesion 3
a) Where on the body was it located: e.g. arm, nose, scalp?			
b) Was the lesion benign or malignant?			
c) What was the diagnosis? i.e. the name advised by your doctor e.g. melanoma, BCC, keratosis etc.			
d) What was the date of diagnosis, biopsy, or treatment?			
e) How was it treated?* See examples of treatment types below.			

* Examples of treatment types: Excised (surgically removed), curettage (removal with a scraping instrument), cryotherapy (freezing off), diathermy (burning off), topical cream e.g. Efudix/Aldara or photodynamic therapy.

3. Have you been advised to have regular skin checks?

   Yes ☐ No ☐ If 'yes', please advise by whom and the frequency.

4. Has any further follow-up or treatment been recommended?

   Name

   Address

   Suburb State Postcode

   Date / /

5. Has any further follow-up or treatment been recommended?

   Yes ☐ No ☐ If 'yes', please provide details.

6. Do you have or can you obtain a copy of any pathology reports which relate to the skin lesion(s)/cancer(s) or sun spot(s) treated?

   Yes ☐ No ☐ If 'yes', please attach a copy to this application.

7. Does your regular doctor, skin specialist or skin clinic have details regarding the lesion(s)/cancer(s) or sun spot(s)?

   Yes ☐ No ☐ If 'yes', please indicate which one and provide the name and address if it is not your usual doctor.

   If 'no', please provide the name and address of the doctor who has full details.

   Name

   Address

   Suburb State Postcode

8. Do you have any skin lesions for which you are considering consulting a doctor or seeking medical advice or treatment?

   Yes ☐ No ☐ If 'yes', please provide details.

Special health questionnaires

Hypertension (High Blood Pressure)

1. When were you first diagnosed with hypertension? / /

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition?
   Yes ☐ No ☐ If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two readings/tests, including dates and any change to your treatment.

Date	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
/ /		
/ /		

5. Have you had an electrocardiogram (ECG), Blood Pressure monitor or any other heart test?
   Yes No ☐ If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Do you have any complications as a result of hypertension?
   Yes ☐ No ☐ If 'yes', please provide details.

7. Does your regular doctor have details of this condition?
   Yes ☐ No ☐ If 'no', please provide the name and address of the doctor who has full details.

High Cholesterol

1. When were you first diagnosed with high cholesterol/triglycerides? / /

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition?
   Yes ☐ No ☐ If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two cholesterol test results, including dates and any change to your treatment.

Date	Result (If unsure, answer 'unsure')	If treatment was changed, give details
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	

5. Have you had an electrocardiogram (ECG), blood pressure monitor or any other heart test?
   Yes ☐ No ☐ If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Do you have any complications as a result of hypertension?
   Yes ☐ No ☐ If 'yes', please provide details.

7. Does your regular doctor have details of this condition?
   Yes ☐ No ☐ If 'no', please provide the name and address of the doctor who has full details.

Declaration by the insured person

I acknowledge that:

- I/We have understood all the questions in this form and declare that the statements made in this Statement are true and complete and agree that they shall form part of the application for insurance and shall be relied upon by TAL Life Limited in deciding whether to issue a policy including the premiums and terms to offer.
- To the extent that if the answers are not in my own handwriting they have been checked by me and I certify that they are correct to the best of my knowledge.
- I/We understand there is a duty to take reasonable care not to make a misrepresentation to the insurer before entering into a contract of insurance, extending or making changes to existing insurance, and reinstating insurance. I/We also understand that if this duty is not met it can have serious impacts on my insurance.

Signature of the person to be insured ✗ Date d d / m m / y y y y

PART 2 – CONFIDENTIAL REPORT ON THE PERSON TO BE INSURED:

Surname | Given name(s)

Note: Information regarding your findings should NOT be given to any other person other than the examinee under the ACT Health Records (Privacy and Access) Act if the examinee lives in or the examination was conducted in the ACT. Exception may be made, subject to the examinee's consent, if in your opinion there is medical information which should be conveyed to their medical attendant. The company's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The examiner is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

A. Introduction

	Yes	No	If 'yes', please provide details.
A1. Are you acquainted with the examinee:			
a. Professionally – If so, how long?	☐	☐	
b. Personally – If so, how long? If 'No' go to question A2	☐	☐	

i. What was the date, reason and outcome of the last consultation with you?

ii. Please give any detail/s of any adverse first degree family history, known to both yourself and your patient. Note – you are only required to disclose family history information pertaining to first degree blood related family members - living or deceased. (mother, father, sisters, brothers)

Family Member	Condition/Illness	Age at Onset	Age at Death

iii. Please list all medications your patient is taking and indicate the reason for the medication.

Medication	Reason

A2. Is there anything unfavourable in appearance, development or behaviour?	☐	☐	
A3. Do you know of, or is there any indication of past or present abuse of alcohol or of the misuse of drugs?	☐	☐	

B. Measurements

Give the following measurements

B1. Height (without shoes)	Height	cm
B2. Weight (clothed)	Weight	kg
B3. Chest (next to skin)	Chest Expiration	cm
	Chest Inspiration	cm
B4. Hip at superior iliac crest (next to skin)	Hip	cm
B5. Waist at umbilicus (next to skin)	Waist	cm
B6. If chest expansion is less than 5cm, comment as to apparent cause or provide peak flow meter reading if available		

C. Respiratory System

		Yes	No	If 'yes', please provide details.
C1.	Is there any abnormality of the respiratory system to palpitation, percussion or auscultation?	☐	☐	
C2.	Is there any sign of past or present respiratory disease?	☐	☐	
C3.	Is there any history of investigations, referral or treatment?	☐	☐	

D. Circulatory System

D1. What is the rate and character of the pulse?

Pulse rate _____ per min

Character _____

D2. What is the position of the apex beat of the heart? In the _____ from the mid-sternal line _____ interspace _____ cm

		Yes	No	If 'yes', please provide details.
D3.	Is there any evidence of cardiac enlargement?	☐	☐	
D4.	Is there any abnormality in the heart sounds or rhythm?	☐	☐	
D5.	Is any murmur present? If so describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.	☐	☐	

D6. What is the Blood Pressure (Auscultatory method)? The Diastolic level is to be taken at the cessation of all sound. If the first Systolic reading is above 135 or below 100, or the Diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.

Systolic _____ Diastolic _____ mm Hg

Systolic _____ Diastolic _____ mm Hg

Systolic _____ Diastolic _____ mm Hg

		Yes	No	If 'yes', please provide details.
D7.	Is there any abnormality of the peripheral arterial or venous circulation?	☐	☐	
D8.	Do you consider the heart and vascular system to be abnormal?	☐	☐	
D9.	Is the examinee now on treatment for hypertension? If so, and if you have the required information, please state:	☐	☐	
	a. Pre-treatment blood pressure level including date(s)			a.
	b. Duration of treatment, and			b.
	c. Nature of treatment			c.
D10.	Is there any history of investigations, referrals or treatment?	☐	☐	

E. Digestive and Lymphatic Systems

		Yes	No	If 'yes', please provide details.
E1.	Is there any abnormality of tongue, mouth or throat?	☐	☐	
E2.	Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen?	☐	☐	
E3.	Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions?	☐	☐	
E4.	Is a hernia present? If so, describe fully.	☐	☐	
E5.	Is there any history of investigations, referrals or treatment?	☐	☐	

F. Genito-urinary System

		Yes	No	If 'yes', please provide details.
F1.	Examination of the urine. The urine should be passed at the time of the examination. If not, please state circumstances. If albumin or blood is found, an early morning specimen should be examined and findings recorded before completing report.			
	a. Albumin	☐	☐	
	b. Glucose	☐	☐	
	c. Blood	☐	☐	
F2.	Is there any evidence of abnormality of the genito-urinary system? (including abnormal PSA test or STDs)	☐	☐	

F3. Is there any history of investigations, referrals or treatment? ☐ ☐

G. Nervous System

	Yes	No	If 'yes', please provide details.
G1. Is there any defect of vision or abnormality of the eyes?	☐	☐	
G2. Is there any defect in hearing or speech? In cases of present or past ear discharge or deafness, state result of auriscopic examination.	☐	☐	
G3. Is there any evidence or history of: a. mental or psychological abnormality or disorder? (If Yes, please complete the Special health questionnaire). b. any disorder of the central or peripheral nervous system?	☐	☐	
G4. Is there any history of investigations, referrals or treatment?	☐	☐	

H. Musculo-skeletal System and Skin

	Yes	No	If 'yes', please provide details.
H1. Is there any abnormality or history of symptoms of the form or function of: a. the joints?	☐	☐	
b. the muscles or connective tissues?	☐	☐	
c. the back or neck including the cervical and lumbar spine? (If Yes, please complete the Special health questionnaire).	☐	☐	
d. Is there any history of investigations, referrals or treatment?	☐	☐	
H2. Is there evidence of any disorder of the skin?	☐	☐	
H3. Please attach any imaging histology available for these conditions.	☐	☐	

I. Females only

	Yes	No	If 'yes', please provide details.
I1. Is the examinee pregnant? If so, advise expected date of confinement.	☐	☐	/ /
I2. On examination of the breasts, are there changes indicative of mastopathy, cyst(s), tumour or other irregularities?	☐	☐	

I3. Please give date and result of last mammogram or other breast investigations if known.

Date	Result
/ /	
/ /	

I4. Please give date and result of most recent PAP test.

Date	Result
/ /	
/ /	

J. Summary

	Yes	No	If 'yes', please provide details.
J1. Do you consider any medical attendant's report or any special tests are required? (No special tests are to be carried out in connection with the proposal for insurance without the company's authority).	☐	☐	
J2. Do you consider the person examined to be likely to require any surgical operation?	☐	☐	
J3. Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement: disclosed by your medical records and/or knowledge of this patient.	☐	☐	

If more space is required, please attach and sign a separate sheet.

Dated at

Date d d / m m / y y y y

Signature of medical examiner ✗

Qualifications

For Payment of Fee Please complete the following: (BLOCK LETTERS PLEASE)

Name

Address

State Postcode

Telephone ( ) ABN

Special health questionnaires

To be completed if the examinee has any condition not adequately covered earlier in this Medical Examination Form.

1. Name of condition (exact diagnosis)

2. The cause

3. a. Describe symptoms

   b. Date symptoms commenced / /

      Date symptoms ceased / /

   c. How often did the examinee have symptoms?

4. Has the examinee ever been off work or had their normal daily activities restricted in any way because of this condition?

   Yes ☐ No ☐

Date	Duration	Reason/ Restriction
/ /		
/ /		
/ /		

5. Is there any residual, on-going effects or restriction in the examinee's daily activities?

   Yes ☐ No ☐ If 'yes', please provide details.

6. Has the examinee taken regular or occasional medication for this condition?

   Yes ☐ No ☐ If 'yes', please advise names of medication(s), dosage(s) and frequency.

   Are you still taking this medication? Yes ☐ No ☐

7. Has the examinee had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)?

8. Has the examinee had any diagnostic investigations (e.g. scope, scan, x-rays, EEG, ECG etc)? Yes ☐ No ☐

9. Has the examinee ever been in hospital or received emergency treatment for anything related to this condition? Yes ☐ No ☐

10. If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.

11. Details of the most recent visit to a doctor or other therapist for anything related to this condition.

Date	Reason for consultation, investigations, findings, advice
/ /	
Doctor/Therapist name and specialty	
Doctor/Therapist address details	

12. Has further treatment been recommended for this condition?

    Yes ☐ No ☐ If 'yes', please provide details.

13. Does the regular doctor have details of this condition?

    Yes ☐ No ☐ If 'no', please provide name and address of doctor who has full details.

Any Additional Information

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Important

This Medical Examination is a matter of importance to the person you have just examined and it would be appreciated if you would send the report without delay to:

GPO Box 68
Sydney NSW 2001
Telephone 1800 338 102