MEDICAL EXAMINATION REPORT

STRICTLY CONFIDENTIAL TO DOCTOR AND UNDERWRITER

Full name

Date of birth (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Occupation

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 alternative photo ID such as drivers licence. Please state document type.

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

Are you related to the client by birth or marriage? ☐ Yes ☐ No If Yes, please give details below.

Is the client known to you either in a personal or professional capacity?

☐ Yes ☐ No If Yes, please give details below.

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 ☐ No If Yes, please give details below.

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b) Anxiety, depression, nervous breakdown or any other nervous or mental disorder?

☐ Yes ☐ No If Yes, please give details below.

c) Angina, heart attack, hypertension, rheumatic fever, heart murmur, circulatory disease or any other heart disorder?

☐ Yes ☐ No If Yes, please give details below.

d) Stomach, bowel, liver or gall bladder disorder?

☐ Yes ☐ No If Yes, please give details below.

e) Disorders of the muscles, bones or joints, e.g. arthritis or gout?

☐ Yes ☐ No If Yes, please give details below.

f) Kidney, bladder or any other urinary disorder?

☐ Yes ☐ No If Yes, please give details below.

g) Cancers tumours, growths, moles, or enlarged glands of any kind?

☐ Yes ☐ No If Yes, please give details below.

h) CVA/stroke or neurological disorder?

☐ Yes ☐ No If Yes, please give details below.

i) Any disease of the ears, eyes or throat?

☐ Yes ☐ No If Yes, please give details below.

j) Any significant disease, physical abnormality, injury or scarring, not mentioned above?

☐ Yes ☐ No If Yes, please give details below.

k) Diabetes, sugar in the urine, thyroid glandular or blood disorder?

☐ Yes ☐ No If Yes, please give details below.

l) **Females only** – any disorder of the female organs (breasts ovaries, uterus) or abnormality of pregnancy or confinement, e.g. caesarean section or miscarriage?

☐ Yes ☐ No If Yes, please give details below.

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. Have you ever been tested, 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) ☐

Wine (125ml glasses) ☐

Spirits (measures) ☐

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

Cigarettes ☐

Cigars ☐

Gms of tobacco ☐

If you are an ex-smoker, please confirm when you stopped and what your previous usage was.

Do you use nicotine replacement such as e-cigarettes or patches? ☐ Yes ☐ No

c) Has either your smoking or alcohol usage 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)				

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RL360 will use your data and information to allow for the administration of your plan, 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.

You can receive a copy of the information RL360 holds about you free of charge by writing to our Data Protection Officer at: RL360, International House, Cooil Road, Douglas, Isle of Man, IM2 2SP, British Isles, or by emailing dpo@rl360.com. We can reserve the right to not send you your personal data in some circumstances - if we do we will write to you setting out the reasons why.

Our full privacy and cookie policies can be viewed at www.rl360.com/privacy or can be obtained by requesting a copy from our Data Protection Officer.

DECLARATION

To be signed by the person who is being examined.

I declare that the above answers are true to the best of my knowledge and that I have not withheld any information that may influence the assessment or acceptance of this application.

I give my express consent for the information in this form to be processed.

I agree that any supplementary questionnaire will form part of my application to the company and that non-disclosure of any material fact known to me may invalidate the contract.

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 No, please give full details including dates and particulars.

e) Is there any evidence of excessive habits?

☐ Yes ☐ No If No, 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 No, 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.

b) Is it unduly forceful?

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

c) Is the heart enlarged?

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

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 No, please give full details including dates and particulars.

e) Is the heart rhythm normal?

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

4. Pulse

a) Measure the rate and describe the character.

b) What is the state of the arterial walls?

c) Is there any vascular abnormality in the legs or reduced foot pulses?

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

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 No, please give full details including dates and particulars.

e) Is there evidence of any disease of the central nervous system?

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

ii) the spleen?

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

iii) the stomach?

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

iv) the bowels?

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

b) Is there a hernia present?

☐ Yes ☐ No If No, 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.

RL360's medical examiners reference number	
Medical Attendant's full name (please print)	
Qualifications	
Address	
Telephone number	
Email address	
Signature	
Date of birth (dd/mm/yyyy)	☐☐ ☐☐ ☐☐☐☐

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

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