

Confidential short medical report

Policy number	<input type="text"/>
Member number*	<input type="text"/>
Group number* (*Fill in for FundsAtWork)	<input type="text"/>

1: Client details

Name of insured life	<input type="text"/>			
Permanent identity/passport number	<input type="text"/>	Permanent identity number	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date of birth	<input type="text"/>	Passport expiry date	<input type="text"/>	
Cell phone number	<input type="text"/>	Alternative number	<input type="text"/>	
Email address	<input type="text"/>			

2: Instruction to the medical professional filling in the form

The insured life has authorised us to get information from you, for underwriting. We can share it directly with other life offices or through the central database and on behalf of the life offices through the relevant life insurance association. According to the rules, the insured life may ask for information from the database and his/her medical doctor will make such information available to him/her in writing.

Verify the identity of the person that you are examining from a photograph in a valid identity document, passport or driving licence only. Photocopies or faxed copies are not acceptable.

To facilitate full payment, provide us with an invoice.

Note: Medical professionals conducting examinations may not be related in any way to the life to be assured.

3: Declaration by the medical professional

Medical professional's initials	<input type="text"/>		
Medical professional's name and surname	<input type="text"/>		
Postal address	<input type="text"/>		
	Postal code <input type="text"/>		
Telephone number - work	<input type="text"/>	Fax - work	<input type="text"/>
HPC/NC registration number	<input type="text"/>	Practice number	<input type="text"/>
Year of first qualifying	<input type="text"/>		
Your status:	General practitioner* <input type="checkbox"/>	Specialist physician* <input type="checkbox"/>	

** A general practitioner and specialist physician must be registered with the Health Professions Council (HPC) and a registered nurse must be registered with the Nursing Council (NC).*

Qualifications	<input type="text"/>
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I declare that where I am not employed or contracted by Momentum Metropolitan Life Limited, that I have provided the service of completing this document as an independent contractor and that no relationship of Agency will exist between Momentum Metropolitan Life Limited and myself. I further declare that I have taken due and proper care to verify the true identity of the insured life and have witnessed his/her signature and I have inspected the insured life's valid:

Identity document	<input type="checkbox"/>	Temporary identity document	<input type="checkbox"/>		
South African passport	<input type="checkbox"/>	Foreign passport	<input type="checkbox"/>	Driving licence	<input type="checkbox"/>

Signed at	<input type="text"/>
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Signature of medical professional	<input type="text"/>	Date	<input type="text"/>
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4: Personal statement

Has any company ever declined or deferred your application for life, health, dread disease or disability insurance?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If "yes", provide full details

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5: Medical history

5.1 Do you have, or have you ever had any of the following?

If "yes", provide full details of each instance in the answering block following question 13.

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| 1. Disorder of the heart, e.g. rheumatic fever, heart murmur, raised cholesterol, shortness of breath, palpitations, chest pain or discomfort, angina pectoris or coronary thrombosis e.g. heart attack. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. High blood pressure, disease of the blood vessels or circulatory disorder, e.g. stroke, transient ischemic attack, cramps in the calves during exercise or walking. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Respiratory or lung disorders, e.g. tuberculosis, asthma, bronchitis or persistent cough. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Disorder of the digestive system, gall bladder, pancreas or liver, e.g. gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, rectal bleeding, piles or jaundice, or have you ever had a gastroscopy? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Disease or disorder of the kidneys, bladder or reproductive organs, e.g. protein in urine, kidney stones, prostatitis, cystitis or sexually transmitted disease. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Sought medical advice, personal counselling or treatment in connection with sexually transmitted diseases, Aids or HIV infections? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. Disorders of the nervous system, e.g. epilepsy, blackouts or paralysis. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8. Mental disorders, e.g. depression, anxiety, panic attacks or post-traumatic stress disorder. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 9. Eye, ear, nose or throat disorders, e.g. defective vision, hearing loss, ear discharge, hoarseness. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 10. Disorder or disease of the skin, muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 11. Diabetes, raised blood sugar, sugar in the urine, thyroid or other glandular or blood disorder, e.g. anaemia or bleeding disorders. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 12. Cancer, a growth or tumour of any kind, including moles removed (malignant/benign). | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 13. Any other illness, including fibromyalgia, chronic fatigue (yuppie flu), tropical diseases (bilharzia or malaria), or have you had any medical procedures or accidents (including motor vehicle accidents) or been hospitalised? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Question number	Nature and duration of complaint or symptoms	Date	Name and address of attending doctor or hospital	When did you last have symptoms?
		M M Y Y Y Y		M M Y Y Y Y
		M M Y Y Y Y		M M Y Y Y Y
		M M Y Y Y Y		M M Y Y Y Y
		M M Y Y Y Y		M M Y Y Y Y
		M M Y Y Y Y		M M Y Y Y Y
		M M Y Y Y Y		M M Y Y Y Y

5: Medical history (continued)

5.2 For female applicants

1. Have you ever had or do you now have any disorder of the female organs (breasts, ovaries, uterus), or any abnormality of pregnancy or confinement, e.g. caesarean section, miscarriage or abortion? Yes No
 If "yes", provide full details, including dates
2. Are you pregnant? Yes No If "yes", how many weeks? weeks
3. Do you:
- 3.1 regularly have Pap smears? Yes No
- 3.2 regularly have mammograms? Yes No
- 3.3 If "yes", provide details of the most recent results
4. In the past five years, have you:
- 4.1 Had any X-rays, ECGs or other examinations, including any angiograms, echocardiograms, biopsies, genetic testing or tumour markers, operations or been hospitalised? Yes No
- 4.2 Taken any prescription medicine or over-the-counter-medicine other than for colds or flu for any condition for longer than ten days? Yes No
- 4.3 Consulted any doctors or specialists, including alternative medical practitioners or traditional healers and/or undergone regular routine checks? Yes No

If "yes" to any of the above, provide details in the schedule below:

Question number	Exact nature of examination, consultations and treatments	Date						Name and address of doctor, specialist or hospital	Results of examinations	Date of latest symptoms					
		M	M	Y	Y	Y	Y			M	M	Y	Y	Y	Y

5. Give the names and addresses of usual medical attendants you consulted in the last three years:

Names	Addresses and contact numbers

5.3 Weight/exercise

1. Has your weight changed by more than 5 kg during the last year? Yes No
 If "yes", has it increased or decreased, by how much and for what reason?
 If "no", for how long has your present weight been constant?
2. Do you exercise regularly? Yes No
 If "yes", provide full details including regularity

5: Medical history (continued)

5.4 Habits

(NB: the company reserves the right to perform blood/urine tests for cocaine, cannabis or nicotine.)

1. Do you smoke (this includes vaping, e-cigarettes and hubbly bubby)? Yes No
If "yes", what and how much do you smoke per day?

2. If you have stopped or reduced smoking, give the date of change, and details of your previous smoking habits? D D M M Y Y Y Y

3. What kind and quantity of alcohol do you drink?
 per day per week

4. Have you ever used recreational drugs Yes No
 Cannabis Cocaine Anabolic steroids Other
If "yes", provide full details

5. Have you ever been charged with drunk driving, have you stopped or reduced drinking, or have your friends or family criticised you about your alcohol use? Yes No
If "yes", provide full details, including dates, previous drinking habits and treatment received

6. Have you ever been admitted to or been advised to attend rehabilitation for drug or alcohol abuse? Yes No
If "yes", provide full details, including any treatment

5.5 Family history

	Age if alive	If alive, provide brief description of present state of health. If health is not good, state condition.	Age at death	If deceased, state cause of death
Father				
Mother				
No of brothers				
No of sisters				

1. Are there any circumstances not stated above that may affect the risk of insuring your life, e.g. hazardous pastimes (e.g. flying, microlight aircraft, motor racing or underwater diving)? Yes No
If "yes", provide full details

2. Have you been advised to have or are you planning any doctor visits, medical tests, surgeries or procedures in the next six months? Yes No
If "yes", provide full details

6: Declaration by the insured life

I declare and warrant that this personal statement, whether in my handwriting or not, is complete and true and also that I understand and agree that this statement together with the proposal for insurance on my life and any other documents, will form the basis of the proposed insurance contract.

Signed at

Signature of insured life	<input style="width: 95%; height: 25px;" type="text"/>	Date	<input style="width: 95%; height: 25px;" type="text"/>
Signature of medical professional	<input style="width: 95%; height: 25px;" type="text"/>	Date	<input style="width: 95%; height: 25px;" type="text"/>

7: Medical professional's confidential report

Do not disclose the results of this examination to the insured life or any other unauthorised person. If the insured life urgently needs treatment or further examinations, refer the insured life to his/her personal medical doctor. Do not arrange for additional examinations unless we have given you consent.

7.1 Build and physical condition history

1. Height (without shoes) , m Weight (with clothes) kg
2. Abdomen (must be completed for all insured lives) cm
3. Chest (insp.)* cm Chest (exp.)* cm *not required for female insured lives

State your impression of the general appearance of the applicant (e.g. flabby, thin, muscular, pale, flushed) and comment on any visible abnormalities:

7.2 Cardiovascular system

1. Blood pressure (taken while lying down) Systolic/Diastolic / mm Hg
If the BP is above 140/90, record a second reading preferably at the end of the examination.
Repeat Systolic/Diastolic / mm Hg
2. State the pulse rate: Rate
3. Is the pulse regular? Yes No

7.3 Genitourinary system

The collection of the urine sample must form part of the medical examination.

- | | | | | |
|---|---|--|-----------------------------|----------------------|
| 1. Is protein present? | Yes <input type="text"/> <input type="text"/> | No <input type="text"/> <input type="text"/> | If present, please quantify | <input type="text"/> |
| 2. Is glucose present? | Yes <input type="text"/> <input type="text"/> | No <input type="text"/> <input type="text"/> | If present, please quantify | <input type="text"/> |
| 3. Is urobilinogen present? | Yes <input type="text"/> <input type="text"/> | No <input type="text"/> <input type="text"/> | If present, please quantify | <input type="text"/> |
| 4. Is blood present? | Yes <input type="text"/> <input type="text"/> | No <input type="text"/> <input type="text"/> | If present, please quantify | <input type="text"/> |
| 5. Is there any other abnormal finding? | Yes <input type="text"/> <input type="text"/> | No <input type="text"/> <input type="text"/> | If present, please quantify | <input type="text"/> |

If present, please quantify and provide name of test used. For female applicants, if there is any blood present, please advise if the client is menstruating.

7.4 Laboratory and finger prick tests

If only specimen has been taken and sent to a laboratory, please indicate the name of the laboratory to which the test was sent.

8: Medical doctor's payment information

To facilitate full payment, please indicate whether the following has been taken and forwarded to a laboratory.

Urine sample Yes No Blood sample Yes No

8.1 Doctor's banking details

Name of account holder

Bank

Branch

Account number Branch code

Type of account Current Savings Transmission

We pay according to the Momentum fixed rate.

Additional comments

[Empty box for additional comments]

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