

Confidential full medical report

Policy number

Member number\*

Group number\* (\*Fill in for FundsAtWork)

1: Client details

Name of insured life

Permanent identity/passport number

Date of birth

Cellphone number

Email address

Permanent identity number

Yes

No

Passport expiry date

Alternative number

2: Instruction to the medical doctor 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 doctor

Medical doctor's initials

Medical doctor's name and surname

Postal address

Telephone number - work

HPCSA registration number

Year of first qualifying

Your status:

General practitioner\*

Specialist physician\*

Postal code

Fax - work

Practice number

Qualifications

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

Temporary identity document

South African passport

Foreign passport

Driving licence

Signed at

Signature of medical doctor

Date

4: Personal statement

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

Yes

No

If "yes", provide full details

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, eg rheumatic fever, heart murmur, raised cholesterol, shortness of breath, palpitations, chest pain or discomfort, angina pectoris or coronary thrombosis eg heart attack.

Yes

No

2. High blood pressure, disease of the blood vessels or circulatory disorder, eg stroke, transient ischemic attack, cramps in the calves during exercise or walking.

Yes

No

3. Respiratory or lung disorders, eg tuberculosis, asthma, bronchitis or persistent cough.

Yes

No

4. Disorder of the digestive system, gall bladder, pancreas or liver, eg gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, rectal bleeding, piles or jaundice, or have you ever had a gastroscopy?

Yes

No

5. Disease or disorder of the kidneys, bladder or reproductive organs, eg protein in urine, kidney stones, prostatitis, cystitis or sexually transmitted disease.

Yes

No

6. Sought medical advice, personal counselling or treatment in connection with sexually transmitted diseases, Aids or HIV infections?

Yes

No

7. Disorders of the nervous system, eg epilepsy, blackouts or paralysis.

Yes

No

8. Mental disorders, eg depression, anxiety, panic attacks or post-traumatic stress disorder.

Yes

No

9. Eye, ear, nose or throat disorders, eg defective vision, hearing loss, ear discharge, hoarseness.

Yes

No

10. Disorder or disease of the skin, muscles, bones, joints, limbs, spine, eg rheumatism, arthritis, gout, slipped disc or other back trouble.

Yes

No

11. Diabetes, raised blood sugar, sugar in the urine, thyroid or other glandular or blood disorder, eg anaemia or bleeding disorders.

Yes

No

12. Cancer, a growth or tumour of any kind, including moles removed (malignant/benign).

Yes

No

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

No

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, eg 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

5.3 In the past five years, have you:

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

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

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
		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

5.4 Medical personnel

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

Names	Addresses and contact numbers

5.5 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)

5.6 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 bubbly)?

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?

Type/kind

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

5.7 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.

Identity/passport number

Signed at

Signature of insured life

Date

D

D

M

M

Y

Y

Y

Y

Signature of medical doctor

Date

D

D

M

M

Y

Y

Y

Y

## 7: Medical doctor'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 you have received consent from us.

### 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 (eg flabby, thin, muscular, pale, flushed) and comment on any visible abnormalities:

Are any of the following present:

- |  |                          |                         |
|--|--------------------------|-------------------------|
| 1. Any operation scars or skin lesions?  | Yes <input type="text"/> | No <input type="text"/> |
| 2. Signs of hyperlipidaemia, eg arcus cornealis, xanthoma, xanthelasma?                        | Yes <input type="text"/> | No <input type="text"/> |
| 3. Enlarged thyroid or lymphatic glands, breast lumps or tumours found during palpation?       | Yes <input type="text"/> | No <input type="text"/> |
| 4. Any hernias, varicose veins or piles?   | Yes <input type="text"/> | No <input type="text"/> |
| 5. Any signs of ear disease?   | Yes <input type="text"/> | No <input type="text"/> |
| 6. Any deformity, physical abnormalities or signs of back or joint disorders or abnormal gait? | Yes <input type="text"/> | No <input type="text"/> |

Describe in detail any adverse findings and state whether operative or other treatment is needed:

### 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 peripheral pulse readily palpable? Yes  No
4. Are there symptoms and signs of any cardiovascular abnormality, eg signs of cardiac enlargement, cardiac failure, abnormal heart sounds or arrhythmia? Yes  No
- If "yes", provide full details

### 7.3 Respiratory system

1. Is there any indication of past or present disease? Yes  No

Describe any abnormality detected in full, such as deficient air entry, abnormal character of breath sounds or adventitious sounds:

### 7.4 Gastrointestinal system

1. Is there any significant abnormality of the mouth or throat, eg tumour or leukoplakia? Yes  No
2. Is there any indication of disease of the gastrointestinal system, liver or spleen? Yes  No

Describe any unhealthy condition, tenderness, palpable mass or other abnormality in full:

## 7: Medical doctor's confidential report (continued)

### 7.5 Central nervous system

1. Are there any abnormalities with sight (other than refractive errors), hearing and speech?

Yes ☐

No ☐

Describe any evidence of disease of the central nervous system in full:

### 7.6 Genitourinary system

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

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

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

## 8: General

1. Do you know the applicant?

Yes ☐

No ☐

If "yes", in what capacity do you know the applicant?

2. Do you have the results of any previous or special examinations?

Yes ☐

No ☐

If "yes", provide full details and include comments on the reports (we will return the original reports).

3. Do you know of or suspect any other past or present health issues or habits (alcohol, tobacco, drugs, etc) that may influence the insured's life expectancy or ability to follow his/her chosen occupation, or lead to a claim under a medical health plan?

Yes ☐

No ☐

If "yes", provide full details:

4. Would you advise any special examinations (eg blood tests, chest x-rays, lung function tests, cardiologist's or neurologist's opinion) to clarify any of the points of your examination?

Yes ☐

No ☐

If "yes", which examination and why do you advise it?

Additional comments