Manulife

MEDICAL EXAMINER'S REPORT FORM

To:	Representative's Details	*For Official Use Only*
Manulife (Singapore) Pte. Ltd. Reg. No. 198002116D 8 Cross Street #15-01 Manulife Tower Singapore 048424 Tel: 6737 1221	Name : Branch : Code :	Policy Number :

WARNING : PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT CAP. 142, YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

Proposed Life Insured

Full Name (as in NRIC/Passport/Birth Cert.)

Occupation (Please specify exact duties)

Date of Birth (*dd/mm/yyyy*) NRIC/Passport/Birth Cert. No. Gender : ☐ Female ☐ Male Contact No.

Smoking Status

Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? ☐ Yes ☐ No

If Yes, please provide the following details.

Product	Frequency	Current	Past	Date Last Used		
				mm	dd	yyyy
Cigarettes	pack(s) / day					
Cigars	x / day					
Other:	x / day					

Family History

1. **Have either of your parents or sibling(s) ever been diagnosed with:** ☐ Yes ☐ No
   - Amyotrophic lateral sclerosis (also called ALS or Lou Gehrig's disease) or other motor neurone disease,
   - Alzheimer's disease,
   - Cancer,
   - Cystic fibrosis,
   - Diabetes,
   - Familial cardiomyopathy,
   - Haemochromatosis,
   - Heart disease or any other heart condition,
   - Hepatitis,
   - High blood pressure,
   - Huntington's chorea,
   - Kidney disorders (including polycystic kidney disease),
   - Multiple sclerosis,
   - Parkinson's disease,
   - Retinitis pigmentosa,
   - Stroke or
   - any other hereditary disease?

   If Yes, please provide the following details.

Relationship	Medical Condition	Present State of Health	Age when Diagnosed	Age at Death (If applicable)

Health Questions

2) Please provide details of your personal or regular doctor / physician.	Doctor / Physician (1)	Doctor / Physician (2)
i) Name of Doctor / Physician		
ii) Name of Clinic / Hospital		
iii) Reason for Consultation		
iv) Date of last Consultation		
v) Diagnosis / Result of Visit		

3) List any medications (prescribed or non-prescribed) you have taken or are currently taking:

4) Have you ever had or been treated for, or been told by a doctor you had:	✓ *Check where applicable*		*If Yes, please provide details such as condition, dates, duration and results. Give full names and address of doctors, hospitals / clinics.*
	Yes	***No***	
a) Heart attack, chest pain, angina, congestive heart failure, shortness of breath, heart murmur, heart valve disease, high blood pressure, irregular heart beat, or any other disease or disorder of the heart or arteries?			
b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease?			
c) Diabetes (including gestational), elevated blood sugar or glucose intolerance, thyroid disorder, enlarged glands or any other disease or disorder of the glands?			
d) Cancer, tumour, leukaemia, malignant melanoma, or tumours or growths of any kind including fibroids and breast lumps?			
e) Asthma, sleep apnea, bronchitis, emphysema, shortness of breath, pneumonia, tuberculosis, persistent cough, coughing of blood or any other disease or disorder of the lung?			
f) Hepatitis, hepatitis carrier, cirrhosis, ulcer, colitis, recurrent indigestion, gastritis, Crohn's disease, passage of blood or mucous from the bowl or any other disease or disorder of liver, stomach, gallbladder, pancreas, bowl or intestines?			
g) Anaemia, thalassaemia, haematomachrosis, recurrent infection, or any other disease or disorder of the immune system, blood, blood cells or bone marrow or any enlarged lymph node or other lymph node disorder?			
h) Epilepsy, seizures, fainting, dizziness, convulsions or fits, paralysis, Multiple Sclerosis, muscular dystrophy, ALS (Lou Gehrig's Disease), Parkinson's Disease, tremors or any other disease of the nervous system?			
i) Any anxiety, depression, stress, panic attacks, bipolar disorder, suicide attempt or any other mental, nervous or emotional disorder?			
j) Arthritis, gout, chronic fatigue, lupus, fibromyalgia, fracture or amputation, back pain or any other injury to or disease or disorder of the spine, bones muscles or joints ?			
k) Kidney stone, sugar protein or blood in the urine or any disease or disorder of the kidney, bladder or urinary tract?			
l) Sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?			
m) Any other health impairment or medically treated condition not already listed?			
5) Do you have any symptom or medical concern for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not yet been completed?			
6) Are you planning to have a medical check up, surgery or be hospitalized?			
7) Have you used or experimented with other drugs or narcotics (other than prescription drugs) within the past 5 years? If Yes, describes drugs, frequency and quantity.			Drugs : _____ Frequency: _____ per week Quantity: _____ per week

	✓ *Check where applicable*		
	Yes	***No***	
8) **Do you currently:** consume alcoholic beverages? If Yes, describes beverages, frequency and quantity. If No, have you ever used alcoholic beverages? If Yes, please provide date and reason stopped.			Beverages: _____ Frequency: _____ per week Quantity: _____ per week Date: _____ Reason Stopped: _____
9) **For Female applicant only** (i) Have you ever had complication of pregnancy such as hypertension, gestational diabetes, etc? ii) Have you ever been diagnosed with, treat for, advised to seek treatment for female related disorder such as (but not limited to) menstrual disorder, disease of the breast or female organs, abnormal PAP smear, abnormal mammogram? (iii) Are you now pregnant? If Yes, how many months?			_____ Months

Declaration

a) I/We declare that no material facts, that is facts likely to influence the assessment and acceptance of this application have been withheld and to the best of my/our knowledge and belief the information given above herein is true and complete.

b) The Insurance herein applied for shall not take effect unless and until the application is approved and the first premium thereon is paid in full. I/We agree to inform Manulife if there is any change in the state of health, occupation or activity of the life to be insured between the date of this application or medical examination and the issue date of the policy. On receiving the information of any change, Manulife is entitled to accept or reject my application.

c) I/We agree that in addition to the release of information to any medical source, or other entity mentioned in this section, Manulife (Singapore) Pte. Ltd. is authorised to use and/or disclose as it reasonably deems fit, any information obtained from any source in respect of me/us, that is held by Manulife (Singapore) Pte. Ltd. to representatives and relevant third parties (included but not limited to companies within the Manulife Financial Group reinsurers, my/our financial advisers, financial institutions, credit agencies, direct marketing service providers, investigators, regulatory, governmental and statutory authorities) whether within or outside Singapore. As far as possible Manulife (Singapore) Pte. Ltd. will release such information to such parties on the understanding that the information will be kept strictly confidential.

d) I/We consent to the Company seeking information about me/us from any medical source, insurance office, organization or person and I/we authorise the giving of such information. A photocopy of this authorization shall be as valid as the original.

e) I/We have read Section25(5) Insurance Act Cap. 142 warning stated on the front of the Medical Examiner's Report form.

If a fact is material with respect to the application is not disclosed, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the representative but was not included in the application. Please check to ensure that you are fully satisfied with the information declared in this application.

Dated at Singapore on this _____ day of _____ 20 _____
(Day) *(Month)* *(Year)*

_____ _____

Signature of Proposed Life Insured **Signature of Examiner**

Name : _____ Name (Block Letter) : _____

NRIC/Passport No. : _____ Address and Clinic Stamp : _____

If you wish to understand the list of purposes for which your personal data may be used or disclosed, you may refer to the Statement of Personal Data Protection located at our website (www.manulife.com.sg)

This page is intentionally left blank

EXAMINER'S REPORT

Physical Examination

Full Name (as in NRIC/Passport/Birth Cert.) : _____

NRIC/Passport/Birth Cert. No. : _____

1) Height: _____ cm Weight: _____ kg

Any weight change in the past 12 months? If Yes, amount of: ☐ Weight Loss _____ kg ☐ Weight Gain _____ kg

2) Chest inspiration: _____ Waist: _____ cm } = Ratio: _____

Chest expiration: _____ Hip : _____ cm

3) a) BLOOD PRESSURE

	1	2	3
Systolic			
Diastolic			

b) If the blood pressure is found to be in excess of 140 Systolic or 90 Diastolic (5th phase), please take two further readings with intervals of 5 minutes.

c) If Insured is hypertensive, please take 3 BP readings.

4) a) Pulse Rate: _____ ☐ Regular ☐ Irregular

b) Type of Irregularity: _____ (c) If extra systoles, please state no. per minute: _____

Section 2 - Complete only for Medical Examinations

1) On examination is / are there any:

i) Extra or abnormal heart sounds? ☐ Yes ☐ No

ii) Murmurs? ☐ Yes ☐ No

iii) Cardiomegaly or cardiac enlargement? ☐ Yes ☐ No
If Yes, please provide details below.

iv) Inadequate circulation anywhere? ☐ Yes ☐ No
(e.g. shortness of breath, edema, stasis dermatitis, PVD)

2) Please complete the following heart chart if any YES answers to question 1, if there is any pulse irregularity, if any blood pressure reading is over 150/100 or a history of hypertension or heart disease.

i) Murmur If more than one, describe in details below.

☐ None ☐ Systolic ☐ Diastolic Grade I II III IV V VI ☐ Loud ☐ Harsh ☐ Rough ☐ Soft ☐ Blowing

ii) Signs of Failure

Shortness of breath? ☐ Yes ☐ No

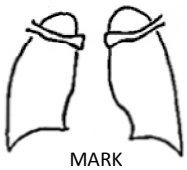
Cyanosis ? ☐ Yes ☐ No

Engorgement of neck veins? ☐ Yes ☐ No

Swelling of ankles? ☐ Yes ☐ No

Rales at lung bases? ☐ Yes ☐ No

Location



MARK
Area of Murmur by - - - - - - XXXX
Transmission by - - - - - - - - ▸

3) On examination, is there any abnormality of:

i) Respiratory system? ☐ Yes ☐ No

ii) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)? ☐ Yes ☐ No

iii) Eyes, ears, nose, mouth, pharynx, head and neck (incl. vision, optic fundi, hearing, speech, thyroid, etc)? ☐ Yes ☐ No

iv) Skin, lymph nodes, peripheral arteries or veins? ☐ Yes ☐ No

v) Breasts? ☐ Yes ☐ No

vi) Nervous system (incl. reflexes, weaknesses, gait, paralysis, tremors)? ☐ Yes ☐ No

vii) Musculoskeletal system (incl. spine, joints, amputation, deformity)? ☐ Yes ☐ No

viii) If there is any history / current backache episode, please comment on: ☐ Yes ☐ No

SLR function: _____ Neurological deficit: _____ Spinal range of movement: _____

4) a)

Urine Examination				
PH	Albumin	Sugar	Blood	Pus cells or other abnormalities

b) Send specimen for microscopic urinalysis if blood (provided not due to menstruation), sugar or albumin is present OR history of urinary disease.

c) For Female Examinee: to indicate Last Menstrual Period when blood is present.

5)

Visual Acuity * Aided / Unaided		
	Right	Left
Distant		
Near		

6) Are you the attending doctor? ☐ Yes ☐ No
If Yes, please include a summary of your file information.

Summary of Consultations: _____

_____

Details for Yes answers to Health Questions

Question No.	Date	Reason and Treatment Given	Duration of No.	Name of Attending Doctor, Name, Address and Telephone Number of Clinic / Hospital

Declaration by Examiner

1) Indicate any requirements not completed and reason:

_____

_____

2) Please comment and provide any information on the examinee that would assist Manulife's assessment of the application.

_____

_____

3) I certify that I have seen the Proposed Life Insured's Identity Card No. / Passport No. / Birth Certificate No. _____ of which bears resemblance to the person whom I have examined.

4) I hereby certify that I have personally examined the Proposed Life Insured and have correctly and fully reported my findings.

Date	Signature of Examiner	Name of Examiner (Block Letters Please) Address and Clinic Stamp