Manulife

MEDICAL EXAMINER'S REPORT (HIGH NET WORTH)

WARNING: STATEMENT PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966 OF SINGAPORE: 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.

For Official Use Only:

Policy No: .....

To: Manulife (Singapore) Pte. Ltd. Reg. No. 198002116D
8 Cross Street #15-01, Manulife Tower, Singapore 048424.

Representative's Name : | **Representative's Code :**

Name of Firm : | **Branch :**

DETAILS OF PROPOSED LIFE INSURED

Full Name (as in NRIC/Passport/Birth Cert.)	
NRIC / Passport / Birth Certificate No.	
Date of Birth (DD/MM/YYYY)	
Gender	☐ Male ☐ Female
Contact No.	
Occupation (Please specify exact duties)	

Smoking Status

1. 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	Amount / Frequency	Current	Past	Date Last Used
Cigarettes	Stick(s) per day:			
Cigars	Cigar(s) per day:			
Others (please specify)	Other(s) per day:			

Family History

2. 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,
- 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

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

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

5. Have you ever had or been treated for, or been told by a doctor you had (Apart from minor condition such as cold / flu) :	**Yes**	**No**
a. epilepsy, fits, stroke, multiple sclerosis, parkinson's disease, dementia, paralysis, weakness of limb, prolonged headache, tremors, unconsciousness, anxiety, panic attacks, depression or any other nervous / mental disorder?	☐	☐
b. diabetes mellitus, raised blood sugar, thyroid disorder or any other endocrine disorder?	☐	☐
c. ear discharge, nose bleeds, double vision, impaired sight, hearing, speech or any other disorder of ear, eye, nose or throat?	☐	☐
d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, sleep apnoea, chest or breathing complaints / discomfort or any other lung disorder?	☐	☐
e. raised cholesterol, high blood pressure, aneurysm, heart attack, heart murmur, mitral valve prolapse or other heart valve disorder, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart, veins or arteries?	☐	☐
f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles, ulcerative colitis, colon polyp or any other stomach or bowel disorder?	☐	☐
g. jaundice, cirrhosis, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	☐	☐
h. blood, protein or sugar in urine, kidney stones, infection or any other disorder of the kidney, bladder or genital organs?	☐	☐
i. slipped disc, gout, arthritis, pain or deformity or disorder of the muscles, spine, limbs or joints or severe injury?	☐	☐
j. cancer, tumours, cysts or growths of any kind?	☐	☐
k. anaemia, thalassaemia, any other disorder of the blood, advised to abstain from donating blood or receive blood transfusion or blood products on account of haemophilia or any other reason?	☐	☐
l systemic lupus erythematosus, any other autoimmune disease or lymphatic disease?	☐	☐
m. any other illness, disorder, operation, physical disability or accident not mentioned above?	☐	☐
n. In the past 5 years, have you had any test done such as X - ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test? If Yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	☐	☐
o. Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	☐	☐
p. Have you ever had HIV testing done (please state reason and results); in the last 3 months ever had any of the following symptoms for more than one week continuously : fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	☐	☐
6. Within the last 10 years have you:		
a. used amphetamines, barbiturates, cannabis (marijuana), cocaine, hallucinogens, opiates or any prescription drug except in accordance with physician's instructions?	☐	☐
b. been advised to limit or discontinue the use of alcohol or drugs, sought or received, counselling or participated in a group for alcohol or drug use?	☐	☐
7. Do you currently:		
a. consume alcoholic beverages?	☐	☐

If Yes, please provide the type of beverages, frequency and quantity.

Product	**Quantity consumed**	
Beer (1 pint glass = 568ml), (1 small glass / small bottle / can = 330ml)	Pint(s) per week: Can(s) per week:	Glass(es) per week: Bottle(s) per week:
Wine (1 glass = 150ml)	Glass(es) per week:	
Spirits (1 shot / tot = 30ml)	Shot(s) / Tot(s) per week:	

If No, have you ever used alcoholic beverages? ☐ ☐

If Yes, please provide date and reason stopped.

Date	
Reason Stopped	

8. Have any symptoms or medical concerns which you have not consult a doctor or any consultation, testing or investigation recommended by a doctor which has not yet been completed?	☐	☐
9. Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

10. **For Female applicant only**

	Yes	No
a. Have you suffered from or are you aware of any breast lumps or any other disorder of your breasts?	☐	☐
b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorder of the female organs?	☐	☐
c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	☐	☐
d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If Yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	☐	☐
e. Are you now pregnant? If Yes, how many months? _____ months	☐	☐
f. When is your last menstruation? Date: _____		
g. Have you ever had or do you currently have complications during your pregnancy (e.g. ectopic pregnancy, diabetes, high blood pressure, etc)?	☐	☐

If you have answered "Yes" to any of the Question 5(a) to 10, please complete the following.
(Note: Please attach a separate sheet of paper if the space below is insufficient to provide the required details. Please include the Name & Identity Number of the Proposed Life Insured and number the answers to correspond to the question).

Question ( )

i. Please state the Condition / Diagnosis below :
(Please specify as accurately as possible the name of illness or medical problem. Where applicable, please state the area of the body affected (eg. Right leg, left eye).

ii. Date of first symptoms or onset of condition.

iii. Did you have any tests done? ☐ Yes ☐ No
If Yes, please state the following.

Date of tests done:

Type of tests done:

Result of test done:

Reason for test done:

iv. What treatment or medication did you receive and / or take?
Please state the following:

Date:

Details of treatment and / or medication:

v. What was the outcome of the treatment?
(eg. ongoing, complete recovery, recurrent or likely to recur)

vi. Date of last follow-up:

vii. Is there any complications? ☐ Yes ☐ No
If Yes, please provide details and date of last follow-up.

viii. Please provide the name and address of Doctor / Clinic.

Full Name of Doctor:

Name of Clinic (Please indicate the branch):

Contact Number:

Address:

Question ( )

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If Yes, please state the following.

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Type of tests done:

Result of test done:

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Date:

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(eg. ongoing, complete recovery, recurrent or likely to recur)

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If Yes, please state the following.

Date of tests done:

Type of tests done:

Result of test done:

Reason for test done:

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Please state the following:

Date:

Details of treatment and / or medication:

v. What was the outcome of the treatment?
(eg. ongoing, complete recovery, recurrent or likely to recur)

vi. Date of last follow-up:

vii. Is there any complications? ☐ Yes ☐ No
If Yes, please provide details and date of last follow-up.

viii. Please provide the name and address of Doctor / Clinic.

Full Name of Doctor:

Name of Clinic (Please indicate the branch):

Contact Number:

Address:

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 Section23(5) Insurance Act 1966 of Singapore, 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)

To be completed by the Medical Examiner

EXAMINER'S REPORT

Section A - To be completed for all Paramedical and Medical Examination

Questions	Answers
1. a) Please provide Height and Weight.	Height: _____ cm Weight: _____ kg
b) Is there any weight change in the past 12 months? If **Yes**, please provide details.	☐ No change in weight ☐ Weight Loss: _____ kg ☐ Weight Gain: _____ kg
2. Please provide the following measurements:	Chest Inspiration: _____ Chest Expiration: _____ Waist: _____ cm Hip : _____ cm } = Ratio: _____
3. a) Blood Pressure Reading	

	Standing	Sitting	Lying
Systolic (mm Hg)			
Diastolic (mm Hg)			

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

	1st	2nd
Systolic (mm Hg)		
Diastolic (mm Hg)		

c) Please take three blood pressure readings if the examinee is hypertensive.

	1st	2nd	3rd
Systolic (mm Hg)			
Diastolic (mm Hg)			

4. a) Pulse Rate:	Beats / Minute: _____ ☐ Regular ☐ Irregular
b) if the pulse rate is irregular, please state the type of irregularity:	
c) If extra systoles, please state no. per minute.	No. / Minute: _____
5. Please describe examinee's general appearance. (e.g. older than stated age, alert, etc.)	
6. Did anyone accompany the examinee during the examination? If **Yes**, please provide details.	☐ Yes ☐ No Relationship to Examinee: Reason for accompany:
7. Did the examinee understand and answer all the questions asked in connection with the examination? If **No**, please provide details.	☐ Yes ☐ No Details:

Section B - To be completed only for Medical Examinations

Questions	Answers
1. On examination:	
a) Are there any extra or abnormal heart sounds?	☐ Yes ☐ No
b) Are there any murmurs?	☐ Yes ☐ No
c) Are there any signs of cardiomegaly or cardiac enlargement? If **Yes**, please provide details.	☐ Yes ☐ No
d) Is there any inadequate circulation anywhere? (e.g. shortness of breath, edema, stasis dermatitis, PVD, etc)	☐ Yes ☐ No
2. **Please complete the following heart chart if:** ● **there is any YES answers to question 1** ● **there is any pulse irregularity** ● **any blood pressure reading is over 150/100** ● **there is any history of hypertension or heart disease**	
a) **Murmur** Please provide details if there is more than one murmur.	Type : ☐ None ☐ Systolic ☐ Diastolic Grade : I II III IV V VI ☐ Loud ☐ Harsh ☐ Rough ☐ Soft ☐ Blowing Details if there is more than one murmur:
b) **Signs of Failure** Is there any signs of:	
● Shortness of breath?	☐ Yes ☐ No
● Cyanosis?	☐ Yes ☐ No
● Engorgement of neck veins?	☐ Yes ☐ No
● Swelling of ankles?	☐ Yes ☐ No
● Rales at lung base?	☐ Yes ☐ No
3. On examination, is there any abnormality of:	
a) Respiratory system?	☐ Yes ☐ No
b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)?	☐ Yes ☐ No
c) Eyes, ears, nose, mouth, pharynx, head and neck (including vision, optic fundi, hearing, speech, thyroid, etc)?	☐ Yes ☐ No
d) Skin, lymph nodes, peripheral arteries or veins?	☐ Yes ☐ No
e) Nervous system (including reflexes, weaknesses, gait, paralysis, tremors)?	☐ Yes ☐ No
f) Genito-urinary System :	
i) Rectum	☐ Yes ☐ No
ii) External Genitalia	☐ Yes ☐ No
iii) Prostate	☐ Yes ☐ No
● Is there any known history of prostate disorder? If **Yes**, please provide details.	☐ Yes ☐ No Details:
g) Breasts?	☐ Yes ☐ No
h) Musculoskeletal system (including spine, joints, amputation, deformity, etc)?	☐ Yes ☐ No
4) Have you examined the examinee in the past year? If **Yes**, please provide reason for examination(s) and date(s).	☐ Yes ☐ No Reason(s): Date(s):
5) Is the examinee your private patient? If **Yes**, please provide details of any medical history which is pertinent to the mortality risk and not already disclosed.	☐ Yes ☐ No Details:

Section C - To be completed only for Examinee aged 71 and over

Please advise the examinee that this part of the examination is an assessment of his / her mobility, daily living activities and memory.

1. **Orientation**
Please record the examinee's answer.

a) What is the current year?	
b) What is the current month?	
c) What is the current date and day?	

2. **Delayed Word Recall - Part 1**

a) Advise the examinee this is memory test. He / She will be shown with 10 words (use the flash card attached at the end of the examiner's report) and will be asked to recall these words at a later time.
- Show the examinee each word.
- Ask the examinee to read each word and use it in a sentence.
- Do not record the sentences.

b) Repeat the process a second time - The examinee is required again to use each word in a sentence. He / She can either make up a new sentence or use the same sentence as the first time.

c) Put the flash card out of sight. Record the time of completion.

Time of completion _____ am / pm

d) This will complete Part 1. Please carry out Part 2 of the Delayed Word Recall in 5 minutes.

3. **Activities of Daily Living**
Please ask the examinee the following questions and record the answers.

a) Does the examinee live alone? If **No**, who does the examinee live with?	☐ Yes Details:	☐ No
b) Does the examinee drive? If **Yes**, to where and for what distance do you drive? If **No**, when and why did you stop driving?	☐ Yes Details:	☐ No
c) Does the examinee have any car accidents in the past 2 years? If **Yes**, please provide details.	☐ Yes Details:	☐ No
d) Does the examinee have a history of falls? If **Yes**, please provide details.	☐ Yes Details:	☐ No
e) Does the examinee have any visits to the hospital emergency room in the past 12 month?	☐ Yes Details:	☐ No
f) Does the examinee exercise? If **Yes**, please provide details including exercise capacity and frequency.	☐ Yes Details:	☐ No
g) Does the examinee belong to any social group, social clubs, do any volunteer work or have any hobbies? If **Yes**, please provide details.	☐ Yes Details:	☐ No
h) How many times a week does the examinee engage in social activities outside his / her home? Please provide details.		
i) Who does the housework at home?		
j) Does the examinee need assistance with any instrumental activities of daily living (e.g. banking, shopping, etc.)? If **Yes**, please provide details.	☐ Yes Details:	☐ No
k) Does the examinee need assistance with any activities of daily living (e.g. feeding, bathing, dressing, etc.)? If **Yes**, please provide details.	☐ Yes Details:	☐ No

4. **Delayed Word Recall - Part 2**

a) If it has 5 minutes since you completed Part 1 of the Delayed Word Recall, please start and complete Part 2 before resuming the remainder of the examination.

b) Ask the examinee to recall as many of the words from Part 1.

Total number recalled correctly: _____

5. **Clock Drawing**
Please have the examinee to draw a clock reading 11.10.

6. **Mobility**
Please record how long it takes the examinee to complete the following task.

a) Get up from seated position, walk 10 feet, return and sit again.	_____ Seconds
b) If the time is greater than or equal to 20 seconds, please comment on any abnormalities of the following:	
• Ability to rise from the chair	☐ Yes ☐ No
• Walking steady or unsteady	☐ Yes ☐ No
• Ability to make turns	☐ Yes ☐ No
• React hesitantly	☐ Yes ☐ No
• Awkward or abnormal gait	☐ Yes ☐ No
• Awkward or abnormal posture	☐ Yes ☐ No

7. **Observations**

a) Does the examinee require the use of any assistive devices (e.g. cane, walker, etc.) or any gait or mobility problems? If **Yes**, please provide details.	☐ Yes ☐ No Details:
b) Does the examinee have any evidence of a cognitive disorder? (e.g. dementia, memory loss, confusion, lack of comprehension, behavioural change, etc.) If **Yes**, please provide details.	☐ Yes ☐ No Details:
c) Describe the examinee personal grooming. (e.g. well-dress, clean, neat, unkempt, fragile, poorly groomed, etc.)	
d) Describe any other general observations or comments you, the examiner, would like to make about the examinee.	

Examiner's Report - Certification and Signature

How did you identify the Examinee? ☐ NRIC ☐ Passport

Examination Location: ☐ Examiner's Office ☐ Others, please state: _____

Indicate completed requirements: ☐ Blood ☐ Urine ☐ ECG ☐ TMX

☐ Others: _____

Indicate any requirements not completed and provide reason(s):

I hereby certify that I have personally examined the Examinee and have correctly and fully report my findings.

Name of Examiner (Please use block letters) Address and Clinic Stamp	Signature of Examiner	Date (DD MMM YYYY)

Flash Word Cards

Use these 10 word flash card for the Delayed Word Recall

TREE	PENCIL
TRAIN	FINGER
PUPPY	FLOWER
DOOR	TOWEL
HAIR	BED