

Macquarie Life Standard Medical Examination Form

Part One – Personal Statement by the Life to be Insured

Made in connection with a proposal for insurance on the life of:

Full name:	Application number:
Address:	
Occupation and Industry:	Date of birth:
Phone number:	

Complete sections A, B and C of the Personal Statement below in your own words prior to the examination. The medical examiner will discuss your answers with you and add any details considered appropriate. Sign the Declaration in the Examiner's presence.

The Medical Examiner is requested to ensure that a clear and complete answer is given to each of the following questions.

A Habits		If 'yes', please give details in the space provided		
A1 (a)	Do you take alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Form:	Daily quantity:
	(b) If no, have you ever taken alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Form:	Daily quantity: Date ceased: / /
A2 (a)	Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Form:	Daily quantity:
	(b) If no, have you ever smoked?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Form:	Daily quantity: Date ceased: / /
A3	Have you used, or injected yourself with, any drug not prescribed by a doctor?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Details:	

B Medical history		
B1 During the last five (5) years have you:		If 'yes', please give full details in schedule below
1	Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2	Been in a hospital, clinic or nursing home?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3	Been advised to have an operation?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4	Had any tests, including blood tests, ECG, X-Rays etc?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5	Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers?	<input type="checkbox"/> No <input type="checkbox"/> Yes
B2	Do you contemplate seeking any examination, advice or treatment (including medical or surgical) in the near future?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Please write full details below of all 'yes' answers to the questions in B1 and B2 above.

Question No.	Date	Name and address of Institution or attending person	Details including condition, treatment, results and length of time off work

B3 Have you EVER had any of the following (please tick appropriate box): If 'yes', please give full details in schedule below

1 Any heart or vascular disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes	18 Persistent diarrhoea, unexplained weight loss, enlarged lymph glands or recurrent fever?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2 High blood pressure?	<input type="checkbox"/> No <input type="checkbox"/> Yes	19 Acquired Immune Deficiency Syndrome (AIDS), and AIDS related condition or AIDS (HIV) antibodies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3 Pain in the chest?	<input type="checkbox"/> No <input type="checkbox"/> Yes	20 Any sexually transmitted disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4 Rheumatic fever?	<input type="checkbox"/> No <input type="checkbox"/> Yes	21 Coughing of blood or passage of blood from the bowel or in the urine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5 Asthma?	<input type="checkbox"/> No <input type="checkbox"/> Yes	22 Any disease of, or injury to, the neck or spine including back strain, disc disorder, lumbago?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6 Bronchitis (intermittent or longstanding)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	23 Arthritis, gout?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7 Any lung complaint?	<input type="checkbox"/> No <input type="checkbox"/> Yes	24 Tendonitis, tenosynovitis, "RSI" or regional pain syndrome?	<input type="checkbox"/> No <input type="checkbox"/> Yes
8 Indigestion, gastric or duodenal ulcer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	25 Any injury, deformity or disease involving any joint or limb?	<input type="checkbox"/> No <input type="checkbox"/> Yes
9 Bowel disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	26 Any impairment of sight, hearing or speech?	<input type="checkbox"/> No <input type="checkbox"/> Yes
10 Hepatitis or any liver or gall bladder disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	27 Any skin disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes
11 Anaemia, leukaemia, haemophilia or other blood disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes	28 Any congenital abnormality?	<input type="checkbox"/> No <input type="checkbox"/> Yes
12 Epilepsy, fainting attacks or fits of any kind?	<input type="checkbox"/> No <input type="checkbox"/> Yes	29 Hernia (rupture)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
13 Paralysis or stroke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	30 Any other operation, disability, illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
14 Mental illness, depression or nervous condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
15 Kidney or bladder disease (including renal, colic, nephritis, pyelitis or cystitis)?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
16 Diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
17 Cancer or tumor of any kind?	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Please write full details below of all 'yes' answers to the questions in B3 above.

Question No. and condition	Date	Name and address of Institution or attending person	Details including condition, treatment, results

C Family history

C1 Has any near blood relative suffered from diabetes, heart disease, mental disorder or breakdown, haemophilia, Huntington's chorea or any hereditary disease? No Yes, please give details

C2 Please fill in the following schedule of family history.

Living			Dead	
	Age	State of health (if not good, state reason)	Age at death	Cause of death (to be stated fully and exactly)
Father				
Mother				
Brothers				
Sisters				

Declaration

I declare that my answers to the questions in this Personal Statement are true and complete. I agree that any Medical Attendant who has been or may hereafter be consulted by me, is directed to divulge to Macquarie or any legal tribunal any information acquired with regard to myself.

I understand that this Personal Statement forms part of my proposal for insurance.

Signature of Life to be Insured:

The above was signed in my presence and discussed where I considered it appropriate.

Signature of Medical Examiner:

Date: / /

Macquarie Life Standard Medical Examination Form

Part Two – Confidential Medical Report to Macquarie Life

On the medical condition of: _____

Note: Information regarding your findings should not be given to any other person. Exception may be made, subject to the examinee's consent, if in your opinion there is medical information which should be conveyed to his/her medical attendant.

The company's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The Examiner is therefore requested **NOT** to express to the examinee any opinion concerning the examinee's insurability.

D Introduction

D1 Are you acquainted with the examinee?	If 'yes', please give details	
(a) Professionally – If so, how long?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
(b) Personally – If so, how long?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
D2 Is there anything unfavourable in appearance, development or behaviour?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
D3 Is there any indication of past or present abuse of alcohol or of the misuse of drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

E Measurements Give the following measurements

E1 Height (without shoes)	Height:	cm				
E2 Weight (clothed)	Weight:	kg				
E3 Chest, and abdomen at umbilicus (next to skin)	Chest Expiration:	cm	Chest Inspiration:	cm	Abdomen:	cm
E4 If chest expansion is less than 5cm, comment as to apparent cause or provide peak flow meter reading if available.						

F Respiratory System

F1 Is there any abnormality of the respiratory system to palpation, percussion or auscultation?	If 'yes' please give details including cause where appropriate.	
	<input type="checkbox"/> No	<input type="checkbox"/> Yes
F2 Is there any sign of past or present respiratory disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

G Circulatory System

G1 What is the rate and character of the pulse?	Pulse rate:	per min	Character:
G2 What is the position of the apex beat of the heart?	In the	interspace,	cm from the mid-sternal line
G3 Is there any evidence of cardiac enlargement?	If 'yes' please give details		
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
G4 Is there any abnormality in the heart sounds or rhythm?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
G5 Is there a murmur present? If so describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
G6 What is the Blood Pressure (auscultatory method)? The diastolic level is to be taken at the cessation of all sound. If the first systolic reading is above 135 or below 100, or the diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.			
Systolic:	Diastolic:	mm Hg	
Systolic:	Diastolic:	mm Hg	
Systolic:	Diastolic:	mm Hg	
G7 Is there any abnormality of the peripheral arterial or venous circulation?	If 'yes' please give details		
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
G8 Do you consider the heart and vascular system to be abnormal ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
G9 Is the examinee now on treatment for hypertension?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If so, and if you have the required information, please state:			
(a) Pre-treatment blood pressure level including date(s):			
(b) Duration of treatment:			
(c) Nature of treatment:			

Continued overleaf

H Digestive and lymphatic systems

- If 'yes' please give details
- H1 Is there any abnormality of tongue, mouth or throat? No Yes
- H2 Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen? No Yes
- H3 Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions? No Yes
- H4 Is a hernia present? If so, describe fully. No Yes

I Genito-urinary system

I1 Examination of the urine. The urine should be passed at the time of the examination. If not, please state circumstances. If albumin is found, an early morning specimen should be examined and the findings recorded before completing report.

- (a) Albumin:
(b) Glucose:
(c) Blood:

- If 'yes' please give details
- I2 Is there any evidence of abnormality of the genito-urinary system? No Yes
- I3 Females – is the examinee pregnant? No Yes, give expected date of confinement:

J Nervous system

- If 'yes' please give details
- J1 Is there any defect of vision or abnormality of the eyes? No Yes
- J2 Is there any defect in hearing or speech? No Yes
In cases of present or past ear discharge or deafness, state result of auriscopic examination:
- J3 Is there any evidence of:
(a) mental abnormality? No Yes
(b) any disorder of the central or peripheral nervous system? No Yes

K Musculo-skeletal system & skin

- If 'yes' please give details
- K1 Is there any abnormality of the form or function of:
(a) the joints? No Yes
(b) the muscles or connective tissues? No Yes
(c) the back or neck including the cervical and lumbar spine? No Yes
- K2 Is there evidence of any disorder of the skin? No Yes

L Summary

- If 'yes' please give details
- L1 Do you consider any medical attendant's reports or any special tests are required? No Yes
(No special tests are to be carried out in connection with the proposal for insurance without the company's authority).
- L2 Do you consider the person examined to be likely to require surgical operation? No Yes
- L2 Comment fully on any unfavourable features (either physical or mental) which could either reduce life expectancy or cause disablement:
(a) in the personal or family medical history:

(b) disclosed by your medical examination:

Important: This Medical Examination is a matter of importance to the person you have examined and it would be appreciated if you would forward the report without delay to Macquarie Life.

Dated at: _____ on _____ / _____ / _____

Signature of Medical Examiner: _____

Qualifications: _____

Payment of fee

Please fill in name and address (BLOCK LETTERS)

Name: _____

Address: _____ Postcode: _____

Phone: (_____) _____

OFFICE USE ONLY

Amount: \$ _____

Date: _____ / _____ / _____

Authorised: _____

How to contact Macquarie

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