Allianz Care

STRICTLY CONFIDENTIAL

Medical Examiner's Report

We ask you, as the Medical Examiner, to complete this form in the presence of the Examinee (the person applying for health insurance cover with us). For your convenience you can save data typed into this form before printing and signing it. If you choose to complete this form in handwriting please use **BLOCK CAPITALS**.

For internal use only:

Name

Application number

If the applicant intends to join an existing company policy, please state:

Group name

Group number

As the Medical Examiner, you are required to obtain answers to the following questions and full information about those conditions likely to shorten life and/or increase liability to sickness and accident.

1 Personal details (please obtain this from the Examinee)

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Surname

Address

Date of birth D D / M M / Y Y Y Y

2. a) Please provide the name, address and contact details of your usual doctor

b) When and why did you last consult a doctor?

When D D / M M / Y Y Y Y

Why

c) Have you smoked any form of tobacco in the last year? Yes ☐ No ☐

If yes, please state amount per day

1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit

d) Do you drink alcohol? Yes ☐ No ☐

If yes, how many units of alcohol do you drink per week per week

1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit

e) Have you ever been treated for excess alcohol consumption or been advised to reduce your alcohol or cigarette consumption. Yes ☐ No ☐

If yes, please provide full details

f) Have you ever taken drugs other than for medicinal purposes? Yes ☐ No ☐

If yes, please provide full details

3. Family history

Have either of your parents or any of your brothers or sisters (living or deceased) suffered from or died from heart disease, cancer (bowel, breast, ovarian or other), diabetes, cardiomyopathy, polycystic kidney disease, stroke, multiple sclerosis, motor neurone disease, Huntington's disease, polyposis of the colon or any other hereditary disorder or familial medical condition before the age of 60? Yes ☐ No ☐

If yes, please state:

Condition(s) diagnosed	Relatives affected by condition(s)		Age at which each affected relative was diagnosed
	☐ One relative	☐ Two or more relatives	
	☐ One relative	☐ Two or more relatives	
	☐ One relative	☐ Two or more relatives	
	☐ One relative	☐ Two or more relatives	

Please use a separate sheet if the space provided is not sufficient

4. Have you ever suffered or had any symptoms of any of the following:

a) Fits, fainting attacks, double vision, blackouts, paralysis, any form of numbness, tingling, temporary loss of muscle power or any other disease of the nervous system? Yes☐ No☐

b) Nervous breakdown, stress, anxiety or depression, tension, compulsions, insomnia or have you ever attended a psychiatrist? Yes☐ No☐

c) Asthma, bronchitis, persistent cough or other lung disease? Yes☐ No☐

d) Chest pains, angina, arrhythmias, palpitations, breathlessness, abnormal blood pressure, raised cholesterol or any heart trouble? Yes☐ No☐

e) Any disease or disorder of the prostate, fallopian tubes, ovaries, cervix, uterus, kidneys or bladder? Yes☐ No☐

f) Rheumatoid arthritis, osteoarthritis, gout, backache or disc trouble? Yes☐ No☐

g) Any disease or disorder of the stomach, liver or bowel including gastric or duodenal ulcer or colitis? Yes☐ No☐

h) Diabetes or any other endocrine or glandular disorder? Yes☐ No☐

i) Tumours, cysts, lumps, moles or swellings? Yes☐ No☐

If any of the above questions were answered Yes, please provide full details:

Question number	Diagnosis / Symptoms	Date(s) diagnosed	Treatment (and date of last treatment)
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	
		D D / M M / Y Y Y Y	

Please use a separate sheet if the space provided is not sufficient

5. Are you currently taking or have you recently been taking any medicines or pills, or have you been on a special diet? Yes☐ No☐

If yes, please provide details

6. Have you undergone any of the following tests/investigations in the last 10 years? Yes☐ No☐

If yes, please provide full details

Test/Investigation	Date of the test/investigation	Results
X-Ray/CT/MRI	D D / M M / Y Y Y Y	
ECG/Exercise ECG/Blood tests/ Cholesterol Test	D D / M M / Y Y Y Y	
Any other medical tests or investigations	D D / M M / Y Y Y Y	
Any operations or procedures	D D / M M / Y Y Y Y	
Any other hospital or day case admissions	D D / M M / Y Y Y Y	

7. Have you ever tested positive for HIV or AIDS, Hepatitis B or Hepatitis C or are you waiting the results of such tests? Yes☐ No☐

8. Is there any other fact, circumstance or information which may affect your application for cover?

NB: We (the Examinee and the Examiner) agree to this medical examination being submitted to Allianz Care on whose behalf the examination has been arranged. We declare that the above statements are true to the best of our knowledge and belief, and that we have not withheld any material fact (facts likely to influence Allianz Care's assessment and acceptance of the application). If in any doubt as to whether a fact is material, then it should be disclosed.

Signature of Examinee

D D / M M / Y Y Y Y

Witnessed by Examiner

D D / M M / Y Y Y Y

2 Physical examination and report (to be completed by the Examiner)

1. General

a) Have you previously attended the Examinee professionally ? Yes☐ No☐

If yes, for what ailments and when?

b) Does appearance of Examinee correspond with age stated? Yes☐ No☐

If no, please provide details

c) Has the Examinee any defects or deformities, enlarged glands (e.g. thyroid or other glands), varicose veins (ulcerated or not), suspicious moles on the skin, scars or abnormality of gait? Yes☐ No☐

If yes, please provide details

d) Have you any reason to suspect that the daily consumption of alcohol or tobacco or any drugs as stated by the Examinee may be understated? Yes☐ No☐

If yes, please provide details

2. Measurements

a) Height cm Weight kg BMI

b) Abdominal girth cm

c) Chest measurement(i) inspiration cm (ii) expiration cm

d) Is weight increasing, decreasing or stationary?

3. Cardiovascular system

a) Are there any heart murmurs? Yes☐ No☐

If yes, please give a complete description

b) Describe the pulse rate rate/min rhythm

(If over 90 please recount at end of examination and note result here rate/min rhythm)

c) What is the position of the APEX beat?

d) Is there any evidence of heart enlargement? Yes☐ No☐

If yes, please provide details

e) Blood pressure

(If the first reading exceeds 140/90 or is otherwise abnormal, please take three further readings at five-minute intervals and report all readings.)

	1st reading	2nd reading	3rd reading
Systolic			
Diastolic (5th phase)			

f) Are the arterial pulses at the feet/ankles present? Yes☐ No☐

If no, please provide details

4. **Ears, nose, throat and eyes**

What is the condition of:

a) Ears (If hearing is defective, state estimated degree of loss)?

b) Nose, mouth and throat?

c) Eyes (e.g. defective vision, retinopathy, inequality of pupils etc.)?

5. **Respiratory system**

a) Do you detect any abnormal physical signs in the upper or lower respiratory tract? Yes☐ No☐

If yes, please provide details

b) Peak flow reading

6. **Nervous system**

a) Are there any signs or symptoms of disease of the brain or nervous system? Yes☐ No☐

If yes, please provide details

b) Are the knee and ankle reflexes normal? Yes☐ No☐

If no, please provide details

7. **Digestive and endocrine system**

a) What is the state of the teeth, gums, tongue and throat?

b) Is hernia present? Yes☐ No☐

If yes, state nature and whether further treatment is planned

c) Is there any enlargement of the liver or spleen or other abdominal abnormality? Yes☐ No☐

If yes, please provide details

8. **Gynaecological** (If the Examinee is a female)

a) Any gynaecological problems, abnormal obstetric history or diseases of the breast? Yes☐ No☐

If yes, please provide details

b) Date and result of last Cervical Smear/Mammogram

c) Breast palpation incl. axillae: any suspicious lumps detected? Yes☐ No☐

9. Genito-urinary system

NB: The urine should be passed at the time of examination

	Result (e.g., normal, +, ++, +++, ++++)
Any albumin abnormalities found?	
Any sugar abnormalities found?	
Any blood abnormalities found?	
Any other findings?	

Is there any evidence of disease of the bladder or kidneys or any other part of the urogenital system? Yes☐ No☐

If yes, please provide full details

10. Additional disclosure

a) Is there any additional statement you wish to make as regards the Examinee's health and their application in general? Yes☐ No☐

If yes, please provide details

b) Do you feel that the patient requires any further investigations or medical intervention? Yes☐ No☐

If yes, please provide details

I confirm that all details in this form are, to the best of my knowledge, true, accurate and complete.

Medical Examiner's signature

Professional qualifications

Date D D / M M / Y Y Y Y

Official stamp of medical provider

3 Payment details (to be completed by the Examinee)

You, as the Examinee, must pay the Medical Examiner for the costs of this medical examination and any additional tests at the time of the consultation. Allianz Care may reimburse the costs if:

a) We accept you on cover and activate your membership, and
b) The charges are reasonable and customary and in accordance with the standard and generally accepted medical procedures.

In order to claim for the reimbursement of these charges, you will need an invoice from the Medical Examiner which states all fees charged. We will pay any applicable and eligible reimbursement (subject to the conditions outlined in points a) and b) above) in the currency of the insurance contract.

Name of bank account holder (as per bank statement)

Account number

IBAN (where required)*

Sort/branch code

BIC/Swift code*

Bank name

Bank address

If you are aware of any additional information required in order to process international transactions within your country (e.g. Agency Code, Tax ID), please list below:

Swift code of intermediary bank (where applicable)

* *If your bank is **within the EU, or if your specific country requires an IBAN (e.g. Qatar, Saudi Arabia, Angola, Tunisia, Turkey)**, please supply **both** your IBAN and BIC/Swift code to to facilitate the payment of your claim.*

Please return the completed and signed form and any required accompanying documentation confidentially to Dr Ulrike Sucher, c/o Underwriting, by:

Email to: underwriting@e.allianz.com
Post to: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

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