Guardian Group

Guardian Life of The Caribbean Limited

GROUP HEALTH PLAN
MEDICAL EXAMINER'S REPORT

1. Proposed Applicant (please print)	2. Date of Birth Day | Month | Year	3. Height – in shoes .....cms	4. Weight – clothed .....kg
5. Marital Status [ ] Married [ ] Single [ ] Widowed [ ] Divorced	6. Any weight change in the past year? Reason [ ] Yes [ ] No [ ] Gain [ ] Loss cms.....		

7. A. Name and address of your personal physician?.....
(If none, so state)
B. Date and reason last consulted?.....
C. What treatment was given or medication prescribed?.....

	Yes	No
8. Have you ever been treated for or ever had any known indication of:		
A. Disorder of eyes, ears, nose or throat?	[ ]	[ ]
B. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?	[ ]	[ ]
C. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	[ ]	[ ]
D. Chest pain , palpitation, high blood pressure, rheumatic fever, Heart murmur, heart attack or other disorder of the heart or blood vessels?	[ ]	[ ]
E. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?	[ ]	[ ]
F. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive, organs?	[ ]	[ ]
G. Diabetes, thyroid or other endocrine disorders?	[ ]	[ ]
H. Gout, neuritis, sciatica, rheumatism, arthritis, or disorder of the muscles or bones, including the spine, back or joints?	[ ]	[ ]
I. Deformity, lameness, amputation?	[ ]	[ ]
J. Aids (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?	[ ]	[ ]
K. Enlargement of lymph nodes, glands, chronic diarrhoea, unusual skin lesions, cyst, tumor, cancer or unexplained infections?	[ ]	[ ]
L. Allergies, anaemia, or other disorder of the blood?	[ ]	[ ]
9. A. Do you use alcohol?	[ ]	[ ]
B. How much daily?.....		
10. A. Do you smoke?	[ ]	[ ]
B. How many cigarettes daily?.....		
11. Ever used or dealt in barbiturates, narcotics or other drugs, excitants or hallucinogens, except as medication prescribed by a physician?	[ ]	[ ]
12. Are you under observation or taking treatment?	[ ]	[ ]
13. Other than the above, have you within the past 5 years:		
A. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	[ ]	[ ]
B. Had any mental or physical disorder not listed above?	[ ]	[ ]
C. Had a check-up, consultation, illness, injury or surgery?	[ ]	[ ]
D. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	[ ]	[ ]
E. Had an electrocardiogram, x-ray or other diagnostic test?	[ ]	[ ]
14. Have you ever had military or police deferment, rejection or discharge because of a physical or mental condition?	[ ]	[ ]
15. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	[ ]	[ ]
16. Females Only	[ ]	[ ]
A. Are you now pregnant? How far advanced?.....months		
B. How many children?.....pregnancies?.....		
C. Age of youngest child.....		
D. Have you ever had or been told you had:	[ ]	[ ]
1. Any menstrual disorder?	[ ]	[ ]
2. Any disease of the breast, pelvis?	[ ]	[ ]
3. Any abortions, miscarriages?		
17. Males Only: Are you involved or have you ever been involved in any homosexual activities?	[ ]	[ ]

Details of yes answers:
Identify Question number, circle applicable items, include diagnoses, dates, duration and names and addresses or all attending physicians and medical facilities.

18. Family History: Tuberculosis, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease, Mental Illness or Suicide? Yes No

	If Alive Age	State of Health	If Deceased Age	Cause at Death
Father	.....	.....	.....	.....
Mother	.....	.....	.....	.....
Brothers	.....	.....	.....	.....
Sisters	.....	.....	.....	.....

No. Living.....
No. Dead.....

I have read the above statements and they are complete and true to the best of my knowledge and belief and are in continuation of and form part of my application for insurance to..... Dated.....

.....
Medical Examiner

.....
Proposed Applicant

AUTHORIZATION FORM

THIS FORM MUST BE COMPLETED IN EVERY CASE

I HEREBY AUTHORIZE any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment, any hospital or clinic where I have been a patient for diagnosis, treatment, disease or ailment, or any insurance company to which I have applied, to give full particulars, including any prior medical history, to GUARDIAN LIFE OF THE CARIBBEAN LIMITED to which I am making application for insurance. A photocopy of this authorization shall be as valid as the original.

MEDICAL EXAMINER'S REPORT

1. Name of Applicant

2. Name of Policyholder

3. A. How long have you known the proposed insured?
   B. Is general appearance healthy?

4 (a) Height in shoes.....centimeters MEASURED.....
(b) Weight in ordinary clothes.....kilograms WEIGHED.....

5. BODY MEASUREMENTS
CHEST – EXPIRATION.....cms INSPIRATION.....cms
ABDOMEN.....cms

6. BLOOD PRESSURE – Sitting position
(a) SYSTOLIC DIASTOLIC (b) HAS THE PROPOSED

Cessation of Sound		INSURED EVER BEEN TREATED BY DRUGS FOR HYPERTENSION?
[ ]	[ ]	

AFTER CAREFUL INQUIRY AND EXAMINATION DO YOU FIND PAST OR PRESENT EVIDENCE OF ABNORMALITY OF:

7. CARDIOVASCULAR SYSTEM? YES [ ] NO [ ]
(a) HEART SOUNDS – quality, murmurs, etc.

(Use Stethoscope on bared chest, before and after exercise in sitting, recumbent and left lateral positions)
(b) HEART SIZE YES [ ] NO [ ]

(c) PULSE – Rhythm – Characte

YES [ ] NO [ ]

	At rest	After 10 Toe Touches	2 min. later
Rate	[ ]	[ ]	[ ]

(d) CIRCULATION –Shortness of Breath, edema, suggestive pain, etc YES [ ] NO [ ]

8. LUNGS? Chest Deformity, emphysema rales, etc. YES [ ] NO [ ]

9. ABDOMEN? Visceral organs, external genitalia, size of liver and spleen, evidence of surgery YES [ ] NO [ ]

10. HEAD AND NECK? – Vision, hearing , speech Thyroid, etc YES [ ] NO [ ]

11. SKIN, LYMPH NODES, BREASTS, MUSCLES, BONES OR JOINTS? YES [ ] NO [ ]

12. NERVOUS SYSTEM? – Reflexes, weakness or tremors, mental state YES [ ] NO [ ]

HEART CHART – Complete Heart Chart only if any abnormality of Cardiovascular system including B.P. exceeding 150 systolic or 90 Diastolic

A. IS THERE A MURMUR?.....

B. HOW DOES EXERCISE AFFECT MURMUR?.....
.....

C. HOW DOES CHANGE IN POSITION AFFECT MURMUR?.....
.....

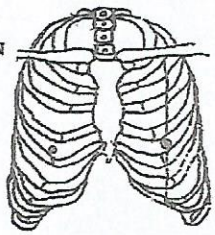
D. IS MURMUR TRANSMITTED?.....WHERE?.....

TIMING		INTENSITY		QUALITY	
SYSTOLIC	[ ]	FAINT	[ ]	SOFT	[ ]
PRESYSTOLIC	[ ]	MODERATE	[ ]	BLOWING	[ ]
DIASTOLIC	[ ]	LOUD	[ ]	ROUGH	[ ]

E. IS THERE A THRILL?.....
F. IS HEART ENLARGED?.....
G. IS THERE ABNORMAL ACCENTUATION OF THE HEART SOUNDS?.....

H. IS THERE EVIDENCE OF DECOMPENSATION?.....

Indicate on chart position of apex, maximum point of intensity of murmur, area over which heard and the direction of transmission.



PLEASE COMMENT FULLY IN THIS SPACE ON ANY ABNORMAL FINDINGS OBTAINED THROUGH INQUIRY OR EXAMINATION - INCLUDE RECOMMENDATIONS FOR ADDITIONAL TESTS OR INVESTIGATION.

13. HAVE YOU REASON TO BELIEVE THAT THERE IS ANYTHING UNFAVOURABLE ABOUT HABITS IN REGARD TO ALCOHOL OR DRUGS?

14. DO YOU KNOW OF ANY SIGNIFICANT MEDICAL HISTORY OR INFORMATION NOT ALREADY MENTIONED ON EITHER SIDE OF THIS FORM YES [ ] NO [ ]
Comment here or by confidential letter to Medical Consultant, Guardian Life of the Caribbean Limited.

15. URINALYSIS – Results of Examiner's urinalysis – SUGAR PRESENT?.....PROTEIN PRESENT?.....SPECIFIC GRAVITY.....
A microscopic urinalysis is required if:
(i) Abnormality of urine noted by examiner of if there is a history of abnormality. (ii) Blood Pressure is elevated.

I have carefully examined.....this day of .....at o'clock AM [ ] PM[ ]
Examination was made in private at [ ] my office [ ] residence of Proposed Applicant [ ] place of business of Proposed Applicant

.....
Medical Examiner's Signature

.....
Examiner's Address

.....
Medical Examiner's Name in Block Letters