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SHORT MEDICAL REPORT

Please return this completed form to ds_uwrequirements@hollard.co.za.

1. Life insured's details

Policy no. ______________________ Identity no. ______________________

Name of insured ____

2. Applicant's details (to be completed by a nurse employed by a doctor or an approved nursing service provider)

I, ______________________________ (name of medical examiner making this declaration)

employed by ______________________________ (name of medical practice or clinic)

______________________ (practice no.) declare that I have taken due care to verify the true identity of

______________________________________ (name of applicant).

I have inspected the applicant's:

- ☐ Identity document — Identity no. ______________________
- ☐ Passport — Passport no. ______________________
- ☐ Other means of photographic identification (specify) ______________________

I understand that no payment will be made for the examination unless I sign this declaration.

Signature (medical attendant) ______________________ **Date** | D | D | M | M | Y | Y | Y | Y |

3. Statement by life insured

Has any application for life, health, sickness, accident or disability insurance on your life ever been declined, deferred, withdrawn or accepted on special terms or at special rates? YES ☐ NO ☐

If YES, state particulars ____

4. Medical history

Do you have, or have you ever had, problems with or disorders of any of the following? If YES, state full details in the medical history information table on the following page.

4.1	Disorder of the heart, e.g. rheumatic fever, heart murmur, shortness of breath, palpitations, chest pain, angina pectoris or coronary thrombosis	YES ☐	NO ☐
4.2	High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps in the calves with walking or exercise, stroke	YES ☐	NO ☐
4.3	Respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough or tuberculosis	YES ☐	NO ☐
4.4	Disorder of the digestive system, gall bladder, pancreas or liver, e.g. gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, rectal bleeding, piles or jaundice	YES ☐	NO ☐

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4.5	Disease or disorder of the kidneys, bladder or reproductive organs, e.g. protein in urine, kidney stones, prostatitis, cystitis or venereal disease	YES	☐	NO	☐
4.6	Mental disorder/neurological/brain disorder, e.g. brain aneurysm, epilepsy, blackouts, paralysis, anxiety or depression	YES	☐	NO	☐
4.7	Eye, ear, nose or throat disorder, e.g. defective vision, hearing loss or ear discharge	YES	☐	NO	☐
4.8	Disorder or disease of the skin, muscles, bones, joints, limbs or spine, e.g. rheumatism, arthritis, gout, slipped disk or back trouble	YES	☐	NO	☐
4.9	Diabetes, sugar in urine, thyroid or other glandular or blood disorders	YES	☐	NO	☐
4.10	Cancer, growth or tumour of any kind	YES	☐	NO	☐
4.11	Any tropical disease, e.g. bilharzia or malaria	YES	☐	NO	☐
4.12	Any other illness, disorder, undergone any operation, disability or accident	YES	☐	NO	☐

Medical history information

Question no.	Name, duration, and severity of complaint or symptom	Date of diagnosis	Name and address of attending doctor/hospital	When did you last have the symptoms?

5. Information required by female applicants

5.1 Have you ever had or do you currently have any disorder of the female organs (breasts, ovaries, uterus) or any abnormalities of pregnancy or confinement, e.g. caesarean section, miscarriage or abortion? YES ☐ NO ☐

If YES, state full details and give the results of the latest Pap smear if applicable

____

5.2 Are you pregnant now? YES ☐ NO ☐

If YES, how many months? ______________

5.3 If you have children, when was your last child born? D D M M Y Y Y Y

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6. Tests and examinations

6.1 Have you ever been tested for or received any medical advice, counselling or treatment in connection with Aids, any infection by one of the Aids viruses, or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea, syphilis)? YES ☐ NO ☐

6.2 If not already stated, have you during the past 5 years:

a. had any x-rays, ECGs, other examinations, or operations, or been hospitalised? YES ☐ NO ☐

If YES, supply details ____________________

b. taken any course of sedatives, tranquilisers or drugs for medical or other reasons? YES ☐ NO ☐

If YES, state past and present medication dosage and reason for use:

____

____

6.3 Have you ever consulted any doctor or specialist (this includes regular general check-ups)? YES ☐ NO ☐

Exact nature of examination and consultation	Date	Name and address of doctor, specialist or hospital	Result of examination and date of last symptoms

6.4 Give the name, address and telephone number of your usual medical examiner and state how long he/she has been your doctor

____

____

____

7. Mass

7.1 Has your mass altered by more than 3 kg over the past year? YES ☐ NO ☐

If YES, state whether it has increased or decreased, by how much, for what reason, and how long your present mass has been constant

____

____

____

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8. Habits

8.1 Do you smoke? YES ☐ NO ☐

If YES, state what you smoke and how many per day ______

8.2 Have you stopped or reduced smoking? YES ☐ NO ☐

If YES, state the date of change and your previous smoking habits D D M M Y Y Y Y

______

8.3 What kind and quality of alcoholic beverages do you consume? ______

Quantity per day ______ Quantity per week ______

8.4 Have you habitually consumed more in the past, or had an alcohol problem? YES ☐ NO ☐

If YES, state details, including treatment ______

8.5 Have you ever received medical advice to reduce or discontinue your alcohol or tobacco consumption, or have you ever been charged with drunken driving? YES ☐ NO ☐

If YES, state full details ______

8.6 Have you ever consumed, injected or smoked any illegal narcotics? YES ☐ NO ☐

If YES, state full details ______

8.7 Are you taking, or have you ever taken, drugs, tranquillisers or any other medicines in any form for a continuous period of more than two weeks? YES ☐ NO ☐

If YES, state full details ______

9. Family history

9.1 Complete the following family information:

	If living		If deceased	
	Age	**State of health**	**Age**	**Cause of death**
Father				
Mother				
Number of brothers				
Number of sisters				

9.2 If not already stated, have any close blood relatives been diagnosed with diabetes, heart disease, high blood pressure, mental illness, porphyria or any other hereditary disease? YES ☐ NO ☐

If YES, state full details as well as age of diagnosis ______

______

______

______

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10. Risks

Are there any circumstances not disclosed above that might affect the risk of insurance on your life? YES ☐ NO ☐

If YES, state full details ______________________________

11. Declaration by life insured

I declare that the statements above are true and complete and shall form part of my application for insurance and I declare that the statements together with my application shall be the basis of the contract between me and Hollard Life.

I authorise Hollard Life to approach any doctor or medical institution to confirm the details of my medical history.

Please take note of the following Hollard disclosures

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature (life insured) ______________________________ **Date** | D | D | M | M | Y | Y | Y | Y |

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Medical Examination Report

The results of this examination are not to be disclosed to any unauthorised person. (To be completed by medical attendant)

12. Build and physical condition

12.1 Height (without shoes) ______ Mass (in clothes) ______

12.2 For male applicant only: Chest (insp.) ______ (exp.) ______ (abdomen) ______

13. Cardiovascular system

13.1 Blood pressure (to be taken in recumbent posture)

Systolic ______ mm/hg Diastolic ______ mm/hg

13.2 If BP is over 140/90, record a second reading at the end of the examination.

Systolic ______ mm/hg Diastolic ______ mm/hg

13.3 Pulse rate (resting) ______ Is the pulse rate regular? YES ☐ NO ☐

14. Genito-urinary system

14.1	Is protein present?	YES ☐	NO ☐
14.2	Is glucose present?	YES ☐	NO ☐
14.3	Is blood present?	YES ☐	NO ☐
14.4	Is there any evidence of urobilinogen, pus, or mucus threads?	YES ☐	NO ☐
14.5	Is there any other abnormal finding?	YES ☐	NO ☐
14.6	If any of the above are present, state quantity	YES ☐	NO ☐

14.7 Describe fully any indication of disease of the kidneys, bladder, prostate or reproductive organs detected. If protein or sugar is detected, state quantity and test used

______

15. Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1103.

Full name ______

Qualifications ______ Practice no. ______

Work tel. no. ______ Cell no. ______

Email address ______

Postal address ______

Please send your account to ds_doctoraccount@hollard.co.za.

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Please take note of the following Hollard disclosures

I declare that I have personally attended to the patient and that this form has been completed to the best of my knowledge.

Signature (medical attendant) ______________________ **Date**

D	D	M	M	Y	Y	Y	Y

Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.