

STANDARD MEDICAL REPORT

Please return this completed form with any relevant copies 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 the medical attendant)

I, _____ (name of medical attendant 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
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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any application for life, health, sickness, accident or disability insurance on your life ever been declined, deferred, withdrawn or accepted on special terms or at special rates?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	<input type="checkbox"/>	NO	<input type="checkbox"/>
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	<input type="checkbox"/>	NO	<input type="checkbox"/>
4.3 Respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough or tuberculosis	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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	<input type="checkbox"/>	NO	<input type="checkbox"/>

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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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Initials (life insured)

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
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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) _____

12.3 State your impression of the general appearance of the applicant (e.g. flabby, thin, muscular, pale, flushed)

Are there:

12.4 Any operation scars or skin lesions? YES NO

12.5 Signs of hyperlipidaemia (e.g. arcus senilis, xanthelamsa)? YES NO

12.6 Enlarged thyroid or lymphatic glands, breast lump or other tumours? YES NO

12.7 Any hernias or varicose veins? YES NO

12.8 Any signs of ear disease? YES NO

12.9 Any forms of deformity or physical abnormality? YES NO

If YES, describe in detail any adverse findings and state whether operative or other treatment may be required

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

13.4 Are the peripheral pulses palpable in the legs and feet? YES NO

13.5 Are there symptoms of any other cardiovascular abnormality, e.g. cardiac enlargement, cardiac failure, murmur, abnormal heart sounds, arrhythmia or peripheral vascular disease? YES NO

If YES, state full details _____

14. Respiratory system

14.1 Is there any indication of past or present disease? YES NO

If YES, describe fully any abnormality detected, such as deficient air entry, abnormal character of breath sounds or adventitious sounds

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15. Gastro-intestinal system

15.1 Is there any significant abnormality of the throat or mouth (e.g. ulcer, tumour, leucoplakia)? YES NO

15.2 Is there any indication of disease of the stomach, bowels, liver or spleen? YES NO

If YES, describe fully any unhealthy conditions, tenderness, palpable mass or any abnormality detected

16. Central nervous system

16.1 Are sight (other than refractive errors), hearing, speech and gait abnormal? YES NO

16.2 Are the patellar and pupillary reflexes abnormal? YES NO

If YES, describe fully any evidence of disease of the central nervous system

17. Genito-urinary system

17.1 Is protein present? YES NO

17.2 Is glucose present? YES NO

17.3 Is blood present? YES NO

17.4 Is there any evidence of urobilinogen, pus, or mucus threads? YES NO

17.5 Is there any other abnormal finding? YES NO

17.6 If any of the above are present, state quantity YES NO

17.7 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

18. General

18.1 Has the applicant ever had any sexually transmitted diseases? YES NO

If YES, state full details, including results of blood tests done or any other investigations carried out

18.2 Is the applicant known to you? YES NO

If YES, give details of the relationship (e.g. patient, son)

18.3 Do you have any additional information on record that materially affects the applicant's life expectancy, disability risk or the likelihood of claims being made under a medical-type policy? YES NO

If YES, state full details

**If additional information is required from your records,
Hollard Life will specifically request this information and pay the appropriate fee**

Initials (life insured)

19. Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1102.

Full name _____

Qualifications _____ Practice no. _____

Work tel. no. _____ Cell no. _____

Email address _____ Mandatory

Postal address _____

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

20. Declaration by medical attendant

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

Signature _____ Date

D	D	M	M	Y	Y	Y	Y
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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.