Friends Provident International

# Global Term
# Medical examination form

**WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS APPLICATION FORM, FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.**

Please return this report to the Chief Medical Office at Friends Provident International Limited (Singapore Branch), 4 Shenton Way, #11-04/06, SGX Centre 2, Singapore 068807.

## Section 1: Personal statement by the examinee

### A Particulars of examinee (please complete in capital letters)

Please tick all appropriate boxes and sign where indicated.

* please delete as appropriate

1 Title — Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr ☐

2 Surname (as shown on NRIC or passport)

3 First name(s) (as shown on NRIC or passport)

4 Correspondence address

5 Unique identification number (NRIC or passport)

6 Date of birth (DD/MM/YYYY) — ☐☐ ☐☐ ☐☐☐☐

7 Age next birthday — ☐☐

8 Gender — Male ☐ Female ☐

9 Nationality

10 Marital status — Single ☐ Married ☐ Widowed ☐ Divorced ☐

11 Occupation

12 Name of company

13 Address of company

14 Home telephone number

15 Work telephone number

16 Mobile number

## B Please answer the following questions (to be answered by the examinee)

1 Do you have a regular doctor? If '**Yes**', please state the name and address of your regular doctor. Yes ☐ No ☐

**Note to doctor:** For client with significant medical history or chronic medical condition(s), please obtain name of attending doctor/clinic.

2 Please state the type of illness consulted, date of consultations and the result of such consultations with your regular doctor.

For the following questions, if '**Yes**', please give details such as date of occurrence, **names and address of doctor**, results of investigation, type of treatment, any recurrence/fully recovered.

3 Are you currently experiencing symptoms or are you now receiving or considering receiving medical advice/ treatment from a doctor? Yes ☐ No ☐

4 Have you ever undergone any special investigation on the recommmendation of a doctor such as X-ray, ultrasound, ECG, barium meal examination, mammogram etc in the past 5 years? Yes ☐ No ☐

5 Have you ever had or been treated for:

a) Epileptic fits, muscular paralysis, disease of the brain, depression, nervous breakdown, neurosis or any form of nervous or mental disease? Yes ☐ No ☐

b) Any disease of the eye, ear, nose or throat? Yes ☐ No ☐

c) Asthma, bronchitis, pneumonia, tuberculosis, emphysema, persistent cough, spitting of blood or other respiratory illness? Yes ☐ No ☐

d) High blood pressure, high cholesterol, heart disease, heart valve disorder, chest pain or breathlessness, palpitation, stroke, oedema or any other blood vessel disease or disorder? Yes ☐ No ☐

e) Stomach/duodenal ulcer, chronic or recurrent diarrhoea, blood in stools, gastritis, digestive or bowel disorder? Yes ☐ No ☐

For the following questions, if '**Yes**', please give details such as date of occurrence, **names and address of doctor**, results of investigation, type of treatment, any recurrence/fully recovered.

f) Diabetes mellitus, elevated blood sugar, thyroid disorder, gout or any endocrine disease? Yes ☐ No ☐

g) Gall bladder disease, any form of hepatitis or liver disease? Yes ☐ No ☐

h) Protein, blood or pus in the urine, disease of the kidney, bladder or reproductive/genital organs? Yes ☐ No ☐

i) Cancer, tumour, cyst or growth (benign or malignant) of any kind including cancer screening tests that were not normal? Yes ☐ No ☐

j) Systemic lupus erythematous, rheumatic fever, kawasaki disease, arthritis, spine and musculoskeletal disorder? Yes ☐ No ☐

k) Unexplained weight loss, recurrent or persistent fever/cough or night sweats? Yes ☐ No ☐

l) Any sexually transmitted disease, for example syphilis, gonorrhoea, herpes or HIV infection (AIDS)? Yes ☐ No ☐

m) Any other illnesses, hereditary disorders/any hospitalisations or physical injuries not listed above? Yes ☐ No ☐

6 Have you ever received any blood transfusion or ever been refused as a blood donor? Yes ☐ No ☐

7 Have you ever used any tobacco products (including but not limited to cigarettes,cigars, pipes and chewing tobacco)? Yes ☐ No ☐

If '**Yes**', please state details:

Type of tobacco

Average daily consumption

Number of years

Date ceased (if applicable)

8 Do you consume alcohol? Yes ☐ No ☐

If '**Yes**', please state:

Quantity

Type

Frequency

For the following questions, if '**Yes**', please give details such as date of occurrence, **names and address of doctor**, results of investigation, type of treatment, any recurrence/fully recovered.

9 Do you engage in hazardous activity such as aviation (other than as a private farepaying passenger), scuba diving, motor racing, mountaineering, etc? Yes ☐ No ☐

10 Do you engage in activities that will increase exposure to AIDS or AIDS related conditions? Yes ☐ No ☐

11 Have any of your natural parents or siblings died or suffered from (a) heart disease (b) high blood pressure (c) stroke (d) diabetes (e) cancer (f) kidney disease (g) mental disorder (h) muscular disorder or any other hereditary disease? Yes ☐ No ☐

| Relationship | Condition/Cause of death | Age at onset | If Deceased, age at death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Declaration

I declare that the answers were given by me in reply to the questions put to me and to the best of my knowledge and belief the information furnished herein are true and complete and I agree that they are in continuation of and form part of my application and that failure to disclose any material known fact to me may invalidate the policy. I agree to inform Friends Provident International Limited (Friends Provident International) if there is any change in the state of my health or my activities between the date of this health declaration/medical examination and the date full insurance coverage is provided by Friends Provident International to me. I understand that the terms of accepting me as a risk for insurance coverage may vary according to such information received. I authorise any medical source, insurance office to release to Friends Provident International and similarly Friends Provident International to release to any medical source, insurance office, any relevant information concerning me at any time, irrespective of whether the application is accepted by Friends Provident International. A photographic copy of this authorisation shall be as valid as the original.

**If a material fact is not disclosed in this application, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the financial planner but was not included in the application. Please check to ensure that you are fully satisfied with the information declared in this application.**

| | **Examinee** | **Medical examiner** |
|---|---|---|
| Signature(s) | | |
| Date (DD/MM/YYYY) | | |

# Section 2: Medical examiner's confidential report

**THIS EXAMINATION SHOULD BE IN PRIVATE, WITHOUT THE PRESENCE OF A THIRD PARTY EXCEPT AS CHAPERON OR INTERPRETER. THE MEDICAL EXAMINER IS REQUESTED TO SEND THIS REPORT IN A SEALED ENVELOPE AS IT IS STRICTLY CONFIDENTIAL BETWEEN THE COMPANY AND THE EXAMINER. HE OR SHE IS ALSO REQUESTED NOT TO GIVE THE EXAMINEE ANY INFORMATION ON THE RESULT OF THE EXAMINATION. PLEASE NOTE THAT WE MAY BE OBLIGED TO DISCLOSE RESULTS OF THE MEDICAL EXAMINATION TO THE EXAMINEE AT HIS REQUEST.**

## A Please answer the following questions (to be answered by the medical examiner)

Please give full details of any abnormality.

1 Are you personally acquainted with the examinee? Yes ☐ No ☐

If '**Yes**', in what capacity and please provide details of any consultations?

2 **CNS, Skeletal system**

a) Are there any diseases of the central or peripheral nervous system? Yes ☐ No ☐

b) Are the tendon reflexes **abnormal**? Yes ☐ No ☐

c) Any paralysis or tremors? Yes ☐ No ☐

d) Any bones or joints deformity, amputation? Yes ☐ No ☐

3 **Chest**

a) Are the shape, capacity and expansion of the chest **unsatisfactory**? Yes ☐ No ☐

b) Are the breath sounds **abnormal**? Yes ☐ No ☐

If '**Yes**', please describe the adventitious sounds heard.

4 **Heart**

a) Is the Apex beat **abnormal**? Yes ☐ No ☐

b) Are there any signs of hypertrophy or dilatation? Yes ☐ No ☐

c) Are there any **abnormalities** in the heart sounds? Yes ☐ No ☐

d) Are there any murmurs? If Yes, please indicate the grade of murmurs. Yes ☐ No ☐

**Pulse rate** beats/minutes

***Regular / Irregular**

(if pulse is irregular or Pulse >90 or <50/mm, record 3 readings)

| | 1st reading | 2nd reading | 3rd reading |
|---|---|---|---|
| Rate per min | | | |

e) Blood pressure (if SBP>140, or DBP>90 (5th phase), please take 2 further readings with interval of 5 minutes.

If the examinee is hypertensive, please state, if known, the readings with relevant dates.

| **Blood pressure** | 1 | 2 | 3 |
|---|---|---|---|
| Systolic (mm Hg) | | | |
| Diastolic (mm Hg) 5th phase | | | |

**Note to doctor:** For client with MVP or heart murmur, please do reflex 2D echocardiogram with doppler study if you have facilities on site or nearby.

Please give full details of any abnormality.

5 **Abdomen**

a) Are the **liver, spleen, kidneys** palpable? Yes ☐ No ☐

b) Are there any **abnormal abdominal mass**, such as hernia, tumour? Yes ☐ No ☐

c) Are there any symptoms of any digestive disturbances? Yes ☐ No ☐

**Note to doctor:** For hepatitis B carrier, please do reflex liver ultrasound if you have facilities on site or nearby.

6 Are there any diseases of the **thyroid** or **endocrine glands**? Yes ☐ No ☐

**Note to doctor:** For client with thyroid goiter/cyst, please do reflex thyroid ultrasound If you have facilities on site or nearby.

7 Are there any **Ear, Nose** or **Throat** abnormality? Yes ☐ No ☐

8 Are there any diseases of the **Eyes**? Are there any arcus senilis, xanthoma or any signs of vascular abnormality? Yes ☐ No ☐

| **Visual acuity * Aided / Unaided** | | |
|---|---|---|
| | Right | Left |
| Distant | | |
| Near | | |

9 a) **Genitourinary system** Yes ☐ No ☐

Are there any diseases of the **urinary** and **genital** organs? e.g. varicocele, calculus.

b) **Urine examination**

Send specimen for microscopic urinalysis if blood (provided not due to menses) or albumin is present or history of urinary disease. If urine sugar is present, to draw blood for HbAIC and blood sugar (to indicate if its fasting or random).

Female examinee: to indicate LMP when blood is present

| **Urine examination** | | | | |
|---|---|---|---|---|
| PH | Albumin | Sugar | Blood | Pus cells or other abnormalities |
| | | | | |

Please give full details of any abnormality.

10 a) Does he/she has any visible growth, tumour or enlargement? Yes ☐ No ☐

If '**Yes**', please state its location and its nature.

b) Are there any significant changes in his or her appetite, weight and bowel habits recently? Yes ☐ No ☐

If '**Yes**', please elaborate.

c) Are you of the opinion that he/she is particularly exposed to the risk of HIV infection? Yes ☐ No ☐

d) Are there any further medical or information required to enable a correct judgement of the risk? Yes ☐ No ☐

Please give full details of any abnormality.

11 a) Please furnish his/her height and weight.

Height (m) _____ Weight (kg) _____

b) Has the weight increased, decreased or remained the same during the past one year?

Increased ☐ Decreased ☐ Stable ☐

c) Is there any unexplained weight loss?

Yes ☐ No ☐

If '**Yes**', please state how much weight loss (kg) and reasons.

12 Please furnish his/her chest and abdomen measurements.

a) & b) Circumference of chest at nipple level

a) Inspiration (cm) _____

b) Expiration (cm) _____

c) Circumference of abdomen at umbilicus

c) Abdomen (cm) _____

13 In the case of a **Female**:

a) Are there any lumps or lesions in the breasts?

Yes ☐ No ☐

b) Are there any obstetrics or gynaecological abnormalities whether past or present? e.g. Fibroid, ovarian cyst, irregular menstruation etc.

Yes ☐ No ☐

c) Is she now pregnant?

Yes ☐ No ☐

If '**Yes**', please give the gestational stage.

**Note to doctor:**

i) For client with benign ovarian or uterine tumour, please do reflex trans-abdominal pelvis ultrasound if you have facilities on site or nearby.

ii) For client with benign breast cyst/lump, please do reflex breast ultrasound and mammogram (if appropriate).

## B Medical examiner's remarks

Please provide any additional medical/health information of the examinee that would assist Friends Provident International's assessment.

## C Signature

Signature of medical examiner _____

Date of examination (DD/MM/YYYY) __ __ __ __ __ __ __ __

Clinic's stamp _____

## Data privacy

We take the responsibility of handling your personal data very seriously and we will only ask you for details required to process your requests to us. Please be aware of our privacy policy - please visit www.fpinternational.sg/legal/privacy-and-cookies.jsp to view the full policy or this can be provided on request from our Data Protection Officer.

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