Great Eastern Holdings Limited *(Reg. No. 1999 03008M)*
The Great Eastern Life Assurance Company Limited *(Reg. No. 1908 00011G)*

Great Eastern
A member of the OCBC Group

Medical Examination Form

Proposal No: ☐☐☐☐☐☐☐☐☐☐ Distribution Rep. Name: _____ ☐ Individual Life Assurance

Policy No: ☐☐☐☐☐☐☐☐☐☐ Distribution Rep. IAC No: ☐☐☐☐☐☐☐☐☐☐

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP. 142), YOU ARE TO DISCLOSE IN THIS FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY.

A PERSONAL STATEMENT (Questions to be answered by the Examinee)

*Mr / Mrs / Ms / Miss / Mdm / Dr

1 Name of the Life to be Assured

2a) Age: ☐☐ b) Sex ☐ Male ☐ Female * c) NRIC / Passport No / BC*: ☐☐☐☐☐☐☐☐☐

3a) Occupation: _____ b) Name of Company: _____

4 What is the name and address of your regular doctor or any doctor that you have attended in the last 3 years?

Name of Doctor		Address of Doctor	
a) Please state date and reason for last visit to your doctor			
b) Please state diagnosis of condition			
c) Please give details to investigations done			

5 **Note:** This requirement is for Health Plan only, please attach the evidence of results of the following test(s):
a) Microscopic urinalysis (instead of dipstick urine test) b) Resting ECG with 12 leads

PLEASE ANSWER THE FOLLOWING QUESTIONS	Please Tick Yes	No	If answer is "Yes", please supply full details below
6 Are you now receiving or considering to receive any form of medical treatment or investigation from a doctor, or intending to consult any doctor for any reason?	☐	☐	Nature of treatment: _____ Name and address of doctor: _____
7 In the past five (5) years, have you ever had any tests done such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test? Please state reason for test done, date and results.	☐	☐	
8a) Have you ever smoked during the last twelve (12) or twenty four (24) months?	☐	☐	☐ Smoked in last twelve (12) months ☐ Smoked in last twenty four (24) months
b) Do you now smoke?	☐	☐	No. of sticks per day: _____
c) How many years have you been smoking?			No. of years: _____
d) Have you ever been advised to stop smoking by the doctor?	☐	☐	
9a) Have you ever taken addictive drugs / narcotics or been treated for alcoholism or drug addiction?	☐	☐	
b) Do you consume beer, wine or other alcoholic beverages?	☐	☐	Type of alcoholic beverages: _____ Average daily consumption: _____
If any answer is "YES", please give details, including dates, duration, diagnosis, name(s) and address(es) of all attending physician(s) and medical institution(s) 10 Have you ever had or been told that you have or been treated for any of the following medical condition or symptoms?			
a) diabetes, thyroid disorders or any other endocrine disorders?	☐	☐	
b) asthma, bronchitis, pneumonia, tuberculosis, breathlessness, coughing with blood, persistent cough (longer than 4 weeks) or any other lung diseases or disorders?	☐	☐	
c) cardiomyopathy, heart attack, heart murmur, heart valve disorder or disease, high blood pressure, high cholesterol, irregular or fast heart rate, chest discomfort or pain or any other disorders of the heart or blood vessels?	☐	☐	
d) depression, epilepsy, fits, nervous breakdown, paralysis, stroke, numbness, prolonged headache (longer than 4 weeks), weakness of limbs, unconsciousness, or any other neurological, nervous, mental disorders?	☐	☐	

If any answer is "YES", please give details, including dates, duration, diagnosis, name(s) and address(es) of all attending physician(s) and medical institution(s)	Please Tick Yes	No	If answer is "Yes", please supply full details below
e) duodenal ulcer, fatty liver, fistula, gallstone, gastritis, hepatitis, piles, stomach ulcer, blood in the stools, diarrhoea (longer than 1 week), jaundice or any other disorders of the digestive system including stomach, liver, gallbladder, pancreas, intestines, colon and rectum?	☐	☐	
f) kidney infection, kidney stones, urinary tract infection, urinary incontinence, blood in urine, protein in urine or sugar in urine or any other disorders of the kidney, bladder, genital or urinary systems?	☐	☐	
g) arthritis, gout, osteoporosis, slipped disc, any pain, deformity, physical disability or severe injury or any disease or disorder of the muscle, bones, spine, limbs or joints?	☐	☐	
h) anaemia, haemophilia, systemic lupus erythematosus or any other disorders of the blood or autoimmune disease?	☐	☐	
i) impaired hearing, impaired sight, impaired speech, ear discharge, double vision, nose bleeds (intermittent or continuous longer than 1 week) or any other disorders of eyes, ears, nose or throat?	☐	☐	
j) cancer, enlarged nodes, unusual skin lesions, tumours, polyps, cysts or other growths?	☐	☐	
k) excessive weight loss in the past 3 months, fatigue (for more than 1 week) in the past 3 months?	☐	☐	
11 Do you have any other illness, disorder, symptoms, operation, physical disability, accident or injury not mentioned above?	☐	☐	
12 Have you or your spouse ever taken or been advised to take any tests for Sexually Transmitted Disease, including HIV and AIDS? If yes, please complete the table:	☐	☐	**Type of Test** **Date of Test** **Reason for Test** **Test Results** **Name of Doctor** **Name and address of Clinic**
13 Other than for the medical conditions or symptoms that you have already told us about, have you had or been advised to have any medical tests or investigations during the last 5 years? Or do you intend to have any tests or investigations in the coming year? (for example blood test, urine test, X-ray, ECG, Ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check) If yes, please complete the table and attach medical reports:	☐	☐	**Type of Test** **Date of Test** **Reason for Test** **Test Results** **Name of Doctor** **Name and address of Clinic**
14 Have any of your biological parents or brothers or sisters, before age of 60, died or suffered from Cancer, Diabetes, Stroke, Kidney Disease, Heart disease, Parkinson's Disease, Alzheimer's disease, or any other hereditary diseases (for example Polycystic Kidney Disease, Huntington's Chorea)? If yes, please state condition, relationship, age at onset and age at death.	☐	☐	
For Female Applicants only:			
15a) Are you now pregnant?	☐	☐	How many months: _____
b) Have you ever had any complication(s) in previous pregnancy(ies)?	☐	☐	Date: _____ Nature of complication: _____
c) Have you ever been found to have or are you aware of any breast lumps or disease(s) of the breast?	☐	☐	
d) Have you ever had any abnormal Pap Smear test or been told by any doctor to have a repeat Pap Smear within the next six (6) months?	☐	☐	
e) Have you ever had recurrent / persistent irregular / painful / unusually heavy menstruation?	☐	☐	
f) Have you ever been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis, or any other gynaecological investigations?	☐	☐	

B DECLARATION

I hereby declare that the above statements are true to the best of my knowledge and I agree that this declaration shall form part of the proposed contract of assurance.

Signature of Life to be Assured / Parent Proposer
(To be signed by parent proposer if child's age is less than 16 years old)

Date : _____

Signature of Witness (Medical Examiner)

Date : _____

Proposal No: _____ Distribution Rep. IAC No: _____

Policy No: _____ Distribution Rep. No: _____

C MEDICAL EXAMINER'S CONFIDENTIAL REPORT

*Mr / Mrs / Ms / Miss / Mdm / Dr

Name of the Life to be Assured

NRIC / Passport No / BC*:

It is presumed that when a Medical Examiner recommends a risk, he has determined to his entire satisfaction that the Life to be Assured is free from disease or from the effects of disease, and that he is likely to live as long as a normally healthy man of his age. The Medical Examiner is requested to send this report in a sealed envelope as it is strictly confidential between the Company and the Medical Examiner. The Medical Examiner is also requested not to give the Life to be Assured any information as to 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.

Has the weight increased, decreased or remained stationary during the past two years? _____

Give an explanation for any marked change. _____

Height: _____ cm

Weight: _____ kg

Circumference of chest in full inspiration: _____ cm

Circumference of chest in full expiration: _____ cm

Circumference of abdomen at umbilicus: _____ cm

QUESTIONS	Please Tick Yes	No	Please give all details of any abnormality
1a) Are you personally acquainted with the person under examination? If so how long, in what capacity and for what medical conditions?	☐	☐	How many years? _____
b) Does appearance of the examinee correspond with the age stated?	☐	☐	
c) Does the examinee seem to be a person of sober habits?	☐	☐	
2 CNS, MUSCULO-SKELETAL SYSTEM a) Are there any abnormalities in these two organ systems?)	☐	☐	
b Are the tendon reflexes abnormal?	☐	☐	
c) Are there any paralysis or tremors?	☐	☐	
d) Are there any diseases of the spine or joints?	☐	☐	
3 CHEST a) Any abnormality in the chest (eg. chest movement, swelling, deformity and etc.)	☐	☐	
b) Percussion - are there any areas of pathological dullness?	☐	☐	
c) Auscultation - are the breath sounds abnormal? If yes, please describe the abnormal sounds heard.	☐	☐	
4 HEART a) Is the apex beat abnormal? State where the apex beat is felt:	☐	☐	
b) Is there any sign of hypertrophy or dilatation?	☐	☐	
c) Are there any murmurs?	☐	☐	
d) Is there any cyanosis or undue breathlessness on exertion?	☐	☐	
e) Blood pressure - If it is found to be in excess of 140 Systolic or 90 Diatolic (5th phase), please take two further readings with intervals of 5 minutes. (By auscultatory method only) f) Pulse Rate _____ beats / minutes (*Regular / Irregular)			1 / 2 / 3 Systolic Diastolic
5 ABDOMEN a) Are the liver, spleen and kidneys palpable?	☐	☐	
b) Are there any abnormal masses such as hernia, tumour etc?	☐	☐	
6 ENDOCRINE Are there any disease of the thyroid or other endocrine glands?	☐	☐	
7 ENT Are there any ear, nose or throat abnormalities?	☐	☐	
8 Are there any disease of the eyes?	☐	☐	Visual acuity *Aided / Unaided Right / Left Distant Near

QUESTIONS	Please Tick Yes	No	Please give all details of any abnormality
9 URINARY AND REPRODUCTIVE ORGANS a) Are there any diseases of the urinary and genital organs eg varicocele calculus?	☐	☐	Urine Examination PH | Albumin | Sugar | Blood | Pus cells / other abnormalities
b) Are there any scars or other signs of disease past or present?	☐	☐	
10 a) Does he / she have any visible growth, tumour or enlargement?	☐	☐	If so, please state its location and nature: _____
b) Is there any significant change in his / her appetite, weight and bowel habits recently?	☐	☐	If so, please elaborate: _____
c) Are there any special features in personal, family, recreational or occupational history which you think are significant?	☐	☐	
11 Is there any further evidence, medical or otherwise, desirable to enable a correct judgement of the risk?	☐	☐	
12 FOR FEMALE APPLICANTS ONLY: a) Is she now pregnant?	☐	☐	How many months: _____
b) Are there any lumps or lesions in the breasts?	☐	☐	
c) Are there any obstetrics or gynaecological abnormalities whether past / present eg: miscarriage, fibroid, ovarian cyst(s) etc?	☐	☐	
d) Is she currently having her menstruation?	☐	☐	

D DOCTOR'S REMARKS

From the statements issued and from the medical examination, please state your opinion of the examinee with reference to the proposed assurance as to the eligibility for insurance:

***Insurable / Uninsurable**

I certify that I have seen the Life to be Assured's Identity Card No. / Passport No. / Birth Certificate No. _____ , the photograph of which bears resemblance to the person whom I have examined.

Signature of Medical Examiner

Date : _____

Name of Medical Examiner : _____

Qualification : _____

Clinic No. : _____

Note: Please check your answers to ensure that nothing has been omitted.

FOR OFFICE USE ONLY:

**Please delete accordingly.*