PRIVATE AND CONFIDENTIAL
MEDICAL REPORT

Dr.

Applicant Name
Address
Occupation
Date of birth
Application number

Please return this page with your report.

Dear Dr,

A proposal for Life/Health Assurance has been made to this company on the person named above. I would be obliged if you would kindly undertake a full medical examination on this patient. Please return the completed report as soon as possible in the envelope provided. The proposer has been asked to contact you to arrange a suitable appointment.

As the report is strictly confidential you are requested not to disclose to the proposer or to any other person the contents of the report.

The fee of €114.00 will be sent to you on receipt of your report.

Please read this notice to the client prior to completion of the examination.

In accordance with the provisions of Part 4 of the Disability Act 2005 when completing this form you or the client should not advise Zurich Life of the result of any Genetic (DNA or RNA) testing that he/she has received.

However you must tell us if the client has received treatment for, has or is experiencing symptoms of, or has or is having investigations(other than a genetic test) for a genetic condition and you must also give us full information about family history (without disclosing the name of the family member) ,including all genetic conditions.

Thank you for your co-operation.

Yours sincerely,

PART ONE CONFIDENTIAL INFORMATION TO BE BTAINED FROM APPLICANT

Before answering the questions in Part one we would ask you to read the declaration at the end of the section carefully.

1. Family History	**If living**		**If dead**	
	Ages	State of Health	Age At death	Precise information as to the nature of each fatal illness is necessary.
Father				
Mother				
Sisters/Brothers				
Spouse (if any)				
Number of children born (if any)				

2. Personal Details	
a). What is the name and address of your usual doctor **?**	

b). When did you last consult a doctor ?	
c). If this was different from the doctor above, please confirm name and address	
d). What was the reason for this consultation	

3. Medical History	**Yes/No**	**If Yes, please provide details**
a) Are you now or have you recently been taking any medicines or pills, or have you been on a special diet?		
b) Have you had any of the following in the last 10 years? If so, please state when and the results of each test/investigation. • X-Ray • ECG/Exercise ECG/Cholesterol Test • Any other medical tests or investigations • Any operations or procedures • Any other hospital admissions		

c) What is your daily consumption of cigarettes? If you smoked cigarettes in the past please state your daily consumption and the date you ceased smoking.		Currently _____ cigarettes per day Previously _____cigarettes per day Date of cessation _____
d) What is your weekly consumption of alcohol?		_____ units per week
e) Have you ever been treated for excess alcohol consumption or been advised to reduce your alcohol or cigarette consumption?		
f) Have you ever taken drugs for other than medicinal purposes?		
g) Have you ever suffered from or had symptoms of the following: • Fits, fainting attacks, blackouts, paralysis, any form of numbness, tingling, temporary loss of muscle power or any other disease of the nervous system? • Nervous breakdown, stress, anxiety or depression, tension or insomnia or have you ever attended a psychiatrist? • Asthma, bronchitis, persistent cough or other lung disease? • Chest pains, angina, palpitations, breathlessness, abnormal blood pressure, raised cholesterol or any heart trouble? • Any disease of the prostate, ovaries, cervix, uterus kidneys or bladder? • Rheumatoid or Osteo Arthritis, gout, backache or disc trouble? • Any disease or disorder of the stomach, liver or bowel including gastric or duodenal ulcer or colitis? • Diabetes or any other endocrine or glandular disorder • Tumours, cysts, lumps, moles or swellings?		
g) Have you ever tested positive for HIV/AIDS or Hepatitis B or C or are you awaiting the results of such a test?		
j). Is there any other fact, circumstance or information which may affect an application for Insurance?		

I agree that this examination report will form part of my application for Life/Serious Illness/Health insurance and that failure to disclose any material fact known to me may invalidate the contract. A Material Fact is any fact about your health, family history, smoking or drinking habits or any other fact that may increase the risk of you making a claim, or influence the assessment and acceptance of your application by Zurich Life. If you fail to disclose all material facts or provide Zurich Life with full and accurate information any subsequent claim may be rejected and your policy cancelled from the inception date. If you are in any doubt about whether a fact is material you should disclose full details.

Date.....

Witness..... **Signature of Applicant.....**

PART TWO CONFIDENTIAL MEDICAL REPORT ON THE LIFE OF

1. GENERAL	
a. Have you attended the applicant professionally? If so, for what ailments and when?	a. …… …… …… …… ……
b. What is his or her general appearance?	b.
c. Does it correspond with stated age?	c.
d. Has the applicant any defects or deformities, enlarged glands or scars?	d.
e. Have you any reason to suspect that the daily consumption of alcohol or tobacco or any drugs as stated by the Life Proposed may be understated.	e.
2. MEASUREMENTS	
a. Height	a. .....ft.....ins **or** ……cms
b. Weight	b. .....St.....lbs **or** ……kgs
c. Chest measurement: (i) Inspiration (ii) Expiration	c. (i) .....ins (ii) .....ins
d. Abdomen at umbilicus.	d. .....ins
e. Is there any evidence of recent weight gain/loss?	e. ……..
3. CARDIOVASCULAR SYSTEM	
a. Describe the pulse.	a. Rate ..... Rhythm .....

b. Condition of the Blood-Vessels.	b.
c. Blood Pressure. *If the first reading exceeds 140/90 or is otherwise Abnormal, please take three further readings at five minute intervals and report all readings.*	c. Systolic _____ _____ _____ Diastolic (5th Phase)
d. Is there a murmur? If so, please give a complete description.	d.
e. State the position of the Apex beat.	e.
4. RESPIRATORY SYSTEM a. Are there any symptoms of pulmonary disease?	*a.*
b. Do you detect any abnormal physical signs in the chest?	*b.*
5. GASTROINTESTINAL TRACT a. What is the state of the teeth, gums, tongue, and throat?	*a.*
b. Is any abnormality of the abdomen apparent on palpation?	*b.*
c. Is hernia present? If so, state its nature and whether further treatment is planned	*c.*
6. NERVOUS SYSTEMS & ORGANS OF SPECIAL SENSE a. Is there any evidence of disease of the brain or nervous system?	*a.*
b. Is there any abnormality of the papillary and patellar reflexes?	*b.*
c. Is the ear drum perforated?	*c.*
d. Is there any ear discharge?	*d.*
7. GENITO-URINARY SYSTEM The urine must in all cases be passed at the time of examination.	
a. Is there any evidence of disease of the bladder or kidneys or any other part of the Urogenital System?	*a.*
b. Is either (i) Albumin (ii) Sugar, present?	*b.*
IF A FEMALE.	
c. Are the reproductive organs functionally healthy?	*c*
d. Is she now pregnant?	*d*
e. If so, mention any difficulties of pregnancy or labour in the past.	*e*
8. SPECIAL CIRCUMSTANCES	

Is there any additional statement you think it desirable to make as regards the Applicant's health, or the case generally or do you feel that the patient requires any further investigations or medical intervention?	

Please do NOT give the Applicant any information whatever as to the result of your Examination

Date of Examination..... 20.....

Signature of Examiner.....

Place of Examination .....

Professional Qualifications.....

SPACE FOR ADDITIONAL REMARKS

Please print, type or stamp full name and address

Please complete the attached questionnaire

FOR HO USE ONLY			
FEE	PAID	DATE.....	INITIALS.....
		.....	.....

REGISTERED IN IRELAND NO. 58098
REGISTERED OFFICE: ZURICH HOUSE
FRASCATI ROAD BLACKROCK, CO. DUBLIN
TELEPHONE 01 2831301

Name : **Proposal Number :**

HYPERTENSION QUESTIONNAIRE

1. When was your patient first noted to be hypertensive?
What was the blood pressure at that time?

2. Have investigations been made to determine the cause? If yes, what were the results and final diagnosis? **Yes .....** **No .....**

3. Has treatment with antihypertensive or other drugs been given?
If yes,

a) When did treatment commence?
b) What was the average BP immediately prior to treatment?
c) Please give the subsequent and current BP levels including dates,
d) What drugs are being taken? (Please state dosage)
e) Does your patient adhere strictly to the prescribed treatment?
f) Is the condition considered to be satisfactorily controlled?

If treatment has been discontinued, please give date of cessation.

4. Have any complications of hypertension even been noted? **Yes .....** **No .....**

If yes, please give details including the dates and duration of any time off work.

5. Please give the dates and result of any chest X-ray, ECG or other tests that have been performed since treatment was started.

***Signed*_____** ***Date*_____**
***Qualifications*_____**