



MEDICAL
PART 11 OF APPLICATION
FOR INSURANCE

POLICY NUMBER:

HEAD OFFICE: 29 St. Vincent Street, Port of Spain, Republic of Trinidad and Tobago, W.I., Tel: (868) 623-1421, Fax: (868) 627-3821, Email: info@clico.com, Website: clico.com

Proposed Life Insured's Statement to the Authorised Medical Officer

PLEASE PRINT

1. (a) Name in full _____ (b) Marital Status _____
 (c) Occupation _____ (d) Date of Birth _____ / _____ / _____
 (e) Name and address of personal Physician (if none, so state) _____
 (f) Date of last consultation: _____ (g) Reason for last consultation: _____
 (h) Results of last consultation _____

2. **Family history:**
 Have any of your immediate family members had heart or kidney disease, cancer (specify type), blood disorder, diabetes, stroke, mental illness, alcoholism, Huntington's Chorea, amyotrophic lateral sclerosis (Lou Gehrig's Disease), motor nerve disease, multiple sclerosis, polycystic kidney disease, Alzheimer's or any other hereditary disease? YES NO
 If yes, please give details: _____

Please complete the following

	Age	State of health	Age at onset	Age at death	Cause of death
Father					
Mother					
Brother					
Sister					
Spouse					
Children					

3. **Avocations, driving, lifestyle:**
 During the past five years have you:

	Answer "Yes" or "No"	If "Yes" give dates and full particulars
(a) flown, or do you contemplate making any flights other than as a fare paying passenger on a scheduled airline?	<input type="checkbox"/> <input type="checkbox"/>	
(b) participated in any hazardous activities such as motor vehicle racing, parachute jumping, scuba diving, or is any such activity contemplated?	<input type="checkbox"/> <input type="checkbox"/>	
(c) been convicted of two or more speeding violations or has your driver's licence been suspended?	<input type="checkbox"/> <input type="checkbox"/>	
(d) been convicted of a criminal offence?	<input type="checkbox"/> <input type="checkbox"/>	

4. **Travel**
 Do you intend to travel or have you travelled outside the Caribbean or North America for a period exceeding three months? YES NO
 If yes, please indicate below:
 Name of country/ies _____
 Length of stay _____ Date travelled _____ Date returned _____

5. **Smoking**
 In the past 12 months have you smoked cigarettes, cigars, pipe or used any other form of tobacco or tobacco replacement or nicotine product? YES NO
 If yes, please give details: type of tobacco _____
 amount smoked daily _____
 How long have you used tobacco? _____
 Have you been advised to quit smoking for medical reasons? YES NO
 If yes, please indicate the date you have stopped smoking. _____ / _____ / _____
 Month / Day / Year

6.

Medical questions: Have you ever been treated for or had any known indication of:

		Answer "Yes" or "No"		If "Yes" give dates and full particulars.
		<input type="checkbox"/>	<input type="checkbox"/>	
(a)	stroke, transient ischemic attack (TIA), dizziness, fainting, convulsions, headache, nervous breakdown, depression, epilepsy, multiple sclerosis or any other neurological disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	high blood pressure, chest pain, angina, palpitations, heart attack, heart murmur, elevated cholesterol, heart valve disorder or any other disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	asthma, bronchitis, tuberculosis, emphysema, blood spitting, persistent cough or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
(d)	colitis, intestinal bleeding or polyps, ulcer, recurrent indigestion, jaundice, hernia, hepatitis, or any other disease or disorder of the stomach, intestines, rectum, gallbladder, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	sugar, albumin, protein or blood in the urine, nephritis, kidney stones or cysts or any other disorder of the kidneys or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
(f)	have you ever suffered from diabetes, taken insulin or gone on a restricted or special diet?	<input type="checkbox"/>	<input type="checkbox"/>	
(g)	cancer, tumor or any other growth or malignancy, venereal disease, any disorder of the breast, prostate or other reproductive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
(h)	thyroid disorder, enlarged lymph glands, anemia, allergies or any other disorders of the blood or glands?	<input type="checkbox"/>	<input type="checkbox"/>	
(i)	any disorders of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
(j)	rheumatoid arthritis, osteoarthritis or any chronic disorder of the joints?	<input type="checkbox"/>	<input type="checkbox"/>	
(k)	arthritis, paralysis, gout, rheumatic fever, any disorder of skin, muscle, bone or joint including the spine.	<input type="checkbox"/>	<input type="checkbox"/>	
(l)	disorder of the muscles or bones including spinal curvature (scoliosis)?	<input type="checkbox"/>	<input type="checkbox"/>	

7.

(a)	Do you have or have you ever had:			
(i)	Prolonged extreme fatigue for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>	
(ii)	Persistent fever or night sweats for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>	
(iii)	Significant weight loss unrelated to dieting of about 10% of body weight?	<input type="checkbox"/>	<input type="checkbox"/>	
(iv)	Hardening or swelling of the lymph glands in the neck, armpits or groin?	<input type="checkbox"/>	<input type="checkbox"/>	
(v)	Persistent diarrhoea?	<input type="checkbox"/>	<input type="checkbox"/>	
(vi)	A heavy, persistent, often dry cough unrelated to smoking for at least three (3) months?	<input type="checkbox"/>	<input type="checkbox"/>	
(vii)	A thick whitish coating on the tongue or in the throat?	<input type="checkbox"/>	<input type="checkbox"/>	
(viii)	Easy bruising or unexplained bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	
(ix)	Recent, slowly enlarging purplish or discoloured lumps on top or beneath skin?	<input type="checkbox"/>	<input type="checkbox"/>	
(x)	Any recent blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>	
(b)	Do you belong to one of the following AIDS high-risk groups established by the health authorities:			
(i)	Homosexual	<input type="checkbox"/>	<input type="checkbox"/>	
(ii)	Bisexual	<input type="checkbox"/>	<input type="checkbox"/>	
(iii)	Intravenous (I. V.) drug users	<input type="checkbox"/>	<input type="checkbox"/>	
(iv)	Haemophiliacs, or other users of blood products	<input type="checkbox"/>	<input type="checkbox"/>	
(v)	Sexual partners of the preceding groups.	<input type="checkbox"/>	<input type="checkbox"/>	
(c)	AIDS any other disorder of the immune system or test results indicating exposure to the AIDS virus (HIV positive)?	<input type="checkbox"/>	<input type="checkbox"/>	
		Answer "Yes" or "No"		If "Yes" give dates and full particulars
(d)	Have you ever been tested, received medical advice, counselling or treatment in connection with AIDS or an AIDS Related condition? If yes, please give full details (routine testing for blood donation purposes may be ignored).	<input type="checkbox"/>	<input type="checkbox"/>	
(e)	Have you ever been tested, received medical advice or treatment in connection with any sexually transmitted disease including Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	

8. In the last 5 years, have you:
- If "Yes" give dates and full particulars
- a. had a check-up, consultation, illness, surgery, injury or disease not mentioned previously?
- b. missed more than 15 consecutive days of work due to sickness or injury?
- c. been a patient in hospital, clinic, sanatorium or other medical facility?
- d. Have you ever received or applied for a pension, disability benefit or compensation for accident, injury or illness?
- e. had an ECG, X-ray, blood tests or other diagnostic tests?
- f. been advised to have any tests, investigations or surgery which have not yet been undertaken or are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a doctor or received treatment?

9. Alcohol and drugs questions:
- (a) Do you drink alcoholic beverages?
- (b) If yes, indicate the average number of drinks per week: _____
- (c) Have you ever received treatment, been advised to receive treatment or joined an organisation because of your alcohol use?
- (d) Have you ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug, including marijuana, cocaine or heroin?
- (e) Are you now under observation or treatment or taking any prescribed medication?
- (f) If yes, give details _____

10. Are you now in first class health and free from all symptoms of disease?

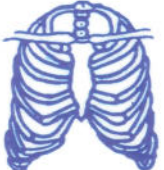
11. Questions For Women ONLY: (If "Yes", give details)
- (a) Have you ever had any menstrual disorder or history of uterine or ovarian disease or menopause?
- (b) Have you had any disease or tumour of breast?
- (c) Have you had any abortion or miscarriage, any toxæmias of pregnancy, or difficulties in labour?
- (d) Give date of last confinement. _____
month / day / year
- (e) Are you now pregnant?
- If so, give date of expected confinement _____
Month / day / year

MEDICAL REPORT ON _____
 (Insert Full Name)

NOT PART OF THE PROPOSED LIFE INSURED'S DECLARATION

<p>1. EXAMINATION OF URINE</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">(a) Specific gravity?</td> <td>Reaction?</td> </tr> <tr> <td>(b) Albumin present?</td> <td>Test used?</td> </tr> <tr> <td>(c) Sugar present?</td> <td>Test used?</td> </tr> <tr> <td>(d) Colour</td> <td></td> </tr> </table> <p>(e) Was specimen of urine examined by you-passed in your presence? YES NO</p>	(a) Specific gravity?	Reaction?	(b) Albumin present?	Test used?	(c) Sugar present?	Test used?	(d) Colour		<p>4. (a) Weight (in ordinary clothing)? _____ kgs.</p> <p>(b) Did you weigh the applicant? _____</p> <p>(c) Change in weight in two years? Increased Decreased</p> <p>(d) If not stationary, give cause and particulars. _____</p>				
(a) Specific gravity?	Reaction?												
(b) Albumin present?	Test used?												
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<p>2. BLOOD PRESSURE (Auscultatory method)</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>SYSTOLIC</td> <td></td> <td></td> <td></td> </tr> <tr> <td>DIASTOLIC</td> <td></td> <td></td> <td></td> </tr> </table>		1	2	3	SYSTOLIC				DIASTOLIC				<p>5. Measurements under waistcoat?</p> <p>(a) Chest at forced expiration? _____ cms.</p> <p>(b) Chest at full inspiration? _____ cms.</p> <p>(c) Abdomen at level of umbilicus? _____ cms.</p>
	1	2	3										
SYSTOLIC													
DIASTOLIC													
<p>3. (a) Height (in shoes) _____ cms.</p> <p>(b) Did you measure applicant? _____</p>	<p>6. PULSE - Rhythm - Character</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">At Rest</td> <td style="text-align: center;">After 10 Toe Touches</td> <td style="text-align: center;">Later</td> </tr> <tr> <td style="text-align: right;">Rate</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		At Rest	After 10 Toe Touches	Later	Rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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7. AFTER CAREFUL INQUIRY AND EXAMINATION DO YOU FIND PAST OR PRESENT EVIDENCE OF ABNORMALITY OF:

		YES	NO													
7.	CARDIOVASCULAR SYSTEMS?			(a) Is there a Murmur? _____												
	(a) HEART SOUNDS - Quality, murmurs, etc (Use stethoscope on bared chest, before and after exercise in sitting, recumbent and left lateral positions.	<input type="checkbox"/>	<input type="checkbox"/>	(b) How does exercise affects Murmur? _____												
	(b) CIRCULATION - Shortness of breath, Edema, suggestive pain etc.	<input type="checkbox"/>	<input type="checkbox"/>	(c) How does change in position affect Murmur? _____												
8.	LUNGS? - Chest deformity, emphysema, rales etc.	<input type="checkbox"/>	<input type="checkbox"/>	(d) Is Murmur transmitted? _____ Where? _____												
9.	ABDOMEN? - Visceral organs, external, genitalia, size of liver and spleen evidence of surgery.	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <thead> <tr> <th>TIMING</th> <th>INTENSITY</th> <th>QUALITY</th> </tr> </thead> <tbody> <tr> <td>Systolic <input type="checkbox"/></td> <td>Faint <input type="checkbox"/></td> <td>Soft <input type="checkbox"/></td> </tr> <tr> <td>Presystolic <input type="checkbox"/></td> <td>Moderate <input type="checkbox"/></td> <td>Blowing <input type="checkbox"/></td> </tr> <tr> <td>Diastolic <input type="checkbox"/></td> <td>Loud <input type="checkbox"/></td> <td>Rough <input type="checkbox"/></td> </tr> </tbody> </table>	TIMING	INTENSITY	QUALITY	Systolic <input type="checkbox"/>	Faint <input type="checkbox"/>	Soft <input type="checkbox"/>	Presystolic <input type="checkbox"/>	Moderate <input type="checkbox"/>	Blowing <input type="checkbox"/>	Diastolic <input type="checkbox"/>	Loud <input type="checkbox"/>	Rough <input type="checkbox"/>
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10.	GENITO - URINARY ORGANS? (Including syphilis or stricture)	<input type="checkbox"/>	<input type="checkbox"/>	(e) Is there a Trill? _____												
11.	HEAD AND NECK? - vision, hearing, speech, thyroid, etc.	<input type="checkbox"/>	<input type="checkbox"/>	(f) Is heart enlarged? _____												
12.	SKIN, LYMPH NODES, BREASTS, MUSCLES, BONES or JOINTS?	<input type="checkbox"/>	<input type="checkbox"/>	(g) Is there abnormal accentuation of the heart sounds? _____												
13.	NERVOUS SYSTEM? - Reflexes, weakness or tremors, mental state	<input type="checkbox"/>	<input type="checkbox"/>	(h) Is there evidence of decompensation? _____												
14.	Have you reason to believe there is anything unfavourable about habits in regard to alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	 <p>Indicate on chart position of apex, maximum point of intensity of Murmur, area over which heard and the direction of transmission.</p>												
15.	HEART CHART - Complete Heart Chart only if any abnormality or cardiovascular system including B.P. exceeding 150 Systolic or 90 Diastolic			16. IS GENERAL APPEARANCE HEALTHY?												
				17. VISIBLE MEANS OF IDENTIFICATION												
				18. Do you know the proposed life insured? (If yes, how long?) Have you had proof of the identity of the person examined, him/her being the proposed life insured? Age nearest birthday as given by proposed life insured. Apparent age.												
				19. ID. CARD NO./PASSPORT NO./DRIVER'S PERMIT NO.												

I HEREBY DECLARE that the Medical examination on the Proposed Life Insured has been completed, with the results herein recorded.

Dated at _____ this _____ day of _____

Proposed Life Insured introduced by _____ Fees \$ _____

Authorized Officer _____

Please carefully review your entire report. See that all questions are properly answered and signed, dated and witnessed and that any corrections or erasures are properly initialed. Address _____

FOR GROUP INSURANCE

Was this examination made for Group Insurance?
 YES No

If Group Insurance complete this section:

Date of Birth: _____ / _____ / _____
month day year

Name of Employer: _____

Address _____

Other reports completed (if any)

Micro-Urinalysis E.C.G. HIV

Other _____

I have read all the statements and answers and they are complete and true. I understand that they shall form a part of the application to COLONIAL LIFE INSURANCE COMPANY (TRINIDAD) LIMITED for insurance to my life. To the extent permitted by the law, I expressly waive, in my name and that of any other person who shall have or claim an interest in any policy issued, reinstated, or changed as the result of these statements and answers, all provisions of the law forbidding any physician or other person who has attended or examined me or who may hereafter attend or examine me, from revealing any details or knowledge which was acquired thereby. I agree to be medically examined if the Company so requests.

Dated at _____ this _____ day of _____

Proposed Life Insured Signature: _____

Signature of Authorized Medical Officer _____