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Proposed Life Insured's Statement to the Authorised Para Medical Officer

PLEASE PRINT

1. (a) Name in full _____ (b) Marital Status _____
 (c) Occupation _____ (d) Date of Birth _____ / _____ / _____
month day year
 (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 family members had heart or kidney disease, blood disorder, diabetes, stroke, mental illness or any other hereditary disease? YES NO

Please complete the following

	Age	State of health	Age at onset	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					
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 as indicated 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 nicotine product? YES NO

If yes, please give details: type of tobacco _____
 amount smoked daily _____

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

- | | | | |
|-----|---|--------------------------|--------------------------|
| (a) | stroke, transient ischemic attack (TIA), dizziness, fainting, convulsions, headache, nervous breakdown, depression, epilepsy, multiple sclerosis or any other 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 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) | 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 partner 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? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, please give full details (routine testing for blood donation purposes may be ignored). | | | |
| <hr/> | | | |

- | | | | |
|--|--------------------------|--------------------------|--|
| (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:

- | | | | |
|--|--------------------------|--------------------------|--|
| a had a check-up, consultation, illness, surgery, injury or disease not mentioned previously? | <input type="checkbox"/> | <input type="checkbox"/> | |
| b missed more than 15 consecutive days of work due to sickness or injury? | <input type="checkbox"/> | <input type="checkbox"/> | |
| c been a patient in hospital, clinic, sanatorium or other medical facility? | <input type="checkbox"/> | <input type="checkbox"/> | |
| d Have you ever received or applied for a pension, disability benefit or compensation for accident, injury or illness? | <input type="checkbox"/> | <input type="checkbox"/> | |
| e had an ECG, X-ray, blood tests or other diagnostic tests? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | |
-

9. Alcohol and drugs questions:

- | | | | |
|---|--------------------------|--------------------------|--|
| (a) Do you drink alcoholic beverages? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (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? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (d) Have you ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug, including marijuana, cocaine or heroin? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (e) Are you now under observation or treatment or taking any prescribed medication? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (f) If yes, give details. _____ | | | |
-

- | | | | |
|--|--------------------------|--------------------------|--|
| 10. Are you now in first class health and free from all symptoms of disease? | <input type="checkbox"/> | <input type="checkbox"/> | |
|--|--------------------------|--------------------------|--|
-

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? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Have you had any disease or tumour of breast? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (c) Have you had any abortion or miscarriage, any toxaeimias of pregnancy, or difficulties in labour? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (d) Give date of last confinement. | | | |
| _____ / _____ / _____ | | | |
| month day year | | | |
| (e) Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If so, give date of expected confinement | | | |
| _____ / _____ / _____ | | | |
| Month day year | | | |
-

PARA MEDICAL REPORT ON _____
(Insert Full Name)

NOT PART OF THE PROPOSED LIFE INSURED'S DECLARATION

<p>1 EXAMINATION OF URINE</p> <p>(a) Specific gravity? Reaction?</p> <p>(b) Albumin present? Test used?</p> <p>(c) Sugar present? Test used?</p> <p>(d) Colour</p> <p>(e) Was specimen of urine examined by you passed in your presence? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>4. (a) Height (in shoes) _____ cms</p> <p>(b) Did you measure applicant? _____</p> <hr/> <p>5. (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>												
<p>2 BLOOD PRESSURE (Auscultatory method)</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width:15%;"></td> <td style="width:20%; text-align:center;">1</td> <td style="width:20%; text-align:center;">2</td> <td style="width:20%; text-align:center;">3</td> </tr> <tr> <td>SYSTOLIC</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td>DIASTOLIC</td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>		1	2	3	SYSTOLIC				DIASTOLIC				<p>6. 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 PULSE - Rhythm - Character</p> <table style="width:100%; margin-top: 10px;"> <tr> <td style="width:30%;"></td> <td style="width:20%; text-align:center;">At Rest</td> <td style="width:20%; text-align:center;">After 10 Toe Touches</td> <td style="width:20%; text-align:center;">Later</td> </tr> <tr> <td>Rate</td> <td style="text-align:center;"><input style="width:40px;" type="text"/></td> <td style="text-align:center;"><input style="width:40px;" type="text"/></td> <td style="text-align:center;"><input style="width:40px;" type="text"/></td> </tr> </table>		At Rest	After 10 Toe Touches	Later	Rate	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>					
	At Rest	After 10 Toe Touches	Later										
Rate	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>										

I HEREBY DECLARE that the Para 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 initialled. 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 Para Medical Officer _____