



Personal Statement & Medical Report

To be completed by Adviser/AMP office prior to issue to examinee

Name & number of Adviser authorising the examination

Proposal Number.

or Name of Superannuation Scheme

This section to be completed by the Person to be Insured

Made in connection with Proposal for Insurance to AMP on the life of:

Full Name In Surname Date of Birth

Block Letters Given names.....

Address:

Please complete sections 1, 2, 3, 4 & 5 of the Personal Statement in your own words prior to the examination.

The Medical Examiner will discuss your answers with you and add any details considered appropriate.

Sign the declaration in the examiner's presence.

You must answer every question fully and truthfully even if you think that any of them are not important.

Please place a ✓ for Yes and a X for No in the box provided. A stroke of the pen cannot be accepted as a reply.

1 Occupation

a Name of employer if currently employed.....

b Present occupation and industry in which you work.....

2 Other Insurance

Has a proposal for Life or Disability Insurance or Superannuation on your life ever been declined or deferred by, or withdrawn from, any Insurance Company, or accepted with an increased premium or otherwise than as submitted? Yes No

If so, give particulars of all such proposals.

.....
.....
.....
.....

3 AIDS Questions

a Do you or any of your current or previous sexual partners have HIV/AIDS, or any sign of HIV infection? (Some signs are: unexplained weight loss, swollen glands and persistent diarrhoea.) Yes No

b In the last 3 years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?

HIV risk situations include but are not limited to:

- sex with or as a prostitute;
- sex with an intravenous drug user;
- contact with someone else's blood eg through injection or scratch with a used needle;
- anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least 3 years).

If yes, please state which

Personal Statement by the Person to be Insured (continued)

4 Health Questions

Yes No

(a) Have you smoked in the last twelve months? Yes No

If Yes, what have you smoked?

How many do you smoke a day?

Do you have, or have you ever had, any of the following conditions or disorders?

Please note the following are only examples. If you have, or have had, a medical condition not listed, tick the 'other' box.
If you answer YES ✓ to any of the questions 4(b) to (q) give more details in the following panel.

(b) Heart, blood vessel or other blood circulation disorder?
Chest pain or discomfort Heart attack Angina High blood pressure
Rheumatic fever Heart murmur Raised cholesterol Aneurysm
Palpitations Other No

(c) Blood disorders?
Anaemia Leukaemia Haemophilia Haemochromatosis
Other No

(d) Lung or other breathing/respiratory disorder?
Asthma Emphysema Bronchitis Tuberculosis
Pleurisy Other No

(e) Kidney, bladder or other urinary or reproductive system disorder?
Kidney stone/Renal colic Prostate disorder Blood in urine Infection
Sexually transmitted disease Hysterectomy Endometriosis Other No

(f) Liver, gall bladder, stomach, bowel or other digestive/gastro-intestinal disorder?
Hiatus hernia Crohn's disease Ulcer Ulcerative colitis
Irritable bowel syndrome Hepatitis Vomiting blood Diverticulosis
Passing blood from the bowel Other No

(g) Brain, neurological or other pathway disorder?
Epilepsy Blackout Dizzy spells Fainting attacks
Fits of any kind Multiple sclerosis Stroke Paralysis
Recurrent headaches Other No

(h) Psychiatric, mental or nervous disorder?
Depression Anxiety Schizophrenia Panic attack
Breakdown Stress distressing enough for you to talk to a doctor or counsellor
Suicide attempt Other No

(i) Cancer, tumour (malignant or benign), growth of any kind or breast lump even if you have not seen a doctor?
Lymphoma Enlarged gland Lump Mole removed
Other lesion removed Prostate cancer Breast cancer Abnormal pap smear
Bowel polyp Other No

(j) Bone, joint, muscle, ligament, cartilage, limb or other musculo-skeletal disorder, pain, or strain or injury?
Spine Neck Back muscles Sciatica
Any joint Arthritis Osteoporosis Tendinitis
RSI/OOS or any regional pain syndrome Other No

(k) Ear, nose, eye, speech or skin disorder? (You don't need to mention long or short sightedness corrected with glasses)
Psoriasis Hearing disorder Tinnitus Allergic or chemical sensitivity reaction Other No

(l) Other condition? (You don't need to mention colds or flu if you recovered quickly)
Diabetes Rheumatoid arthritis Chronic fatigue Thyroid disorder
Fibromyalgia Abnormal blood sugar Gout Other No

(m) Do you take regular medication? (You don't need to mention the contraceptive pill or acne medication.) Yes No

(n) In the last 3 years, have you been to a specialist, or had any medical procedure, investigation or test? Yes No
Eg blood transfusion; operation; x-ray; ECG; mammogram; pap smear; cholesterol; HIV; or any other test.

(o) Have you been advised to have (even if you have not followed this advice) or are you considering seeking medical advice, treatment, tests or an operation? Yes No

(p) Have you ever used any drug or medicines not prescribed by a doctor? Yes No
(You don't need to mention medicines for colds, flu or occasional mild headaches.)

(q) Have you ever received advice or treatment for an alcohol or drug related condition or advice to cut down or stop using alcohol or any drug? (This includes advice you have not followed.) Yes No

The next page of this form must also be completed by the person to be Insured

This section to be completed by the Medical Examiner

On the medical condition of

This form must be posted direct to AMP immediately on completion of the examination

- Note: 1 Information regarding your findings should not be given to the examinee or any other person. Exception may be made subject to the examinee's consent if in your opinion there is medical information which should in the examinee's interests be conveyed to the examinee's medical attendant. The provisions of the Privacy Act will apply to access to the information obtained from the medical examination.
- 2 The AMP's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors including the type of insurance sought. The EXAMINER is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

6 General

- | | If YES, please give details | Yes | No |
|--|-----------------------------|--------------------------|--------------------------|
| a Are you acquainted with the examinee? If so, for how long? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| b Is there anything unfavourable in appearance, development or behaviour? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| c Does the examinee drink alcohol? | | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, what? how much? how often? | | | |
| d Is there any indication of past or present abuse of alcohol or of the misuse of drugs? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| e Are there any permanent marks or scars? | | <input type="checkbox"/> | <input type="checkbox"/> |

7 Measurements

- a Height (without shoes) cm Weight (clothed) kg
- b Chest: Expiration cm; Inspiration cm; Abdomen at umbilicus (next to skin) cm;
- c If chest expansion is less than 5cm comment as to apparent cause, or provide Peak Flow meter reading

8 Respiratory System

- | | If YES, please give details | Yes | No |
|--|-----------------------------|--------------------------|--------------------------|
| a Is there any abnormality of the respiratory system to palpation, percussion or auscultation? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| b Is there any sign of past or present respiratory disease? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| c Is there any history of asthma? If so, please comment on the following:- | | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Frequency | | | |
| (ii) Severity | | | |
| (iii) Medication prescribed including dates of any oral steroid courses or hospitalisation. | | | |
| | | | |
| (iv) What is the peak flow rate today? | | | |

9 Digestive & Lymphatic Systems

- | | If YES, please give details | Yes | No |
|---|-----------------------------|--------------------------|--------------------------|
| a Is there any abnormality of the tongue, mouth or throat? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| b Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| c Is there any abnormality of lymph glands in the neck, axillae or inguinal regions? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| d Is a hernia present? If so, describe fully | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |

10 Circulatory System

If YES, please give details Yes No

- a What is the pulse rate per min. and character (regular or irregular)?
- b What is the position of the apex beat of the heart? In the interspace; cm from the mid-sternal line.
- c Is there any evidence of cardiac enlargement?
-
- d Is there any abnormality in the heart sounds or rhythm? If so, give particulars
- e Is any murmur present? If so describe fully including site, timing, intensity and transmission. Also indicate any effect of posture or respiration on the murmur
-
- f Is there any abnormality of the peripheral arterial or venous circulation?
-
- g What is the blood pressure? (auscultatory method)
- The diastolic level is to be taken at the cessation of all sound. If the first systolic reading is above 135 or below 100, or the diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.*
- Systolic Diastolic mm.Hg.
- Systolic Diastolic mm.Hg.
- Systolic Diastolic mm.Hg.
- h Has the examinee received treatment for hypertension? If "YES", please state:
- (i) duration of treatment Date from: to
- (ii) nature of treatment
- (iii) pre-treatment blood pressure level and date(s)
- i Do you consider any abnormality of the heart and vascular system is present?
-

11 Genito-Urinary System

If YES, please give details Yes No

- a Examination of the urine. (a) Albumin (b) Glucose
-
- The urine should be passed at the time of the examination. If not, please state circumstances. If albumin is found, an early morning specimen should be examined and findings recorded before completing report.*
- b Is there any evidence of abnormality of the genito-urinary system?
-
- c Females: Is the examinee pregnant? If so, give expected date of delivery

12 Nervous System

If YES, please give details Yes No

- a Is there any defect of vision or abnormality of the eyes?
-
- b Is there any defect of hearing or speech? In cases of present or past ear discharge or deafness, state result of auriscopic examination
-
- c Is there any evidence of:
- (i) mental abnormality?
-
- (ii) any disorder of the central or peripheral nervous system?
-

13 Musculo-Skeletal System & Skin

If YES, please give details Yes No

- a Is there any abnormality of the form or the function of:
 - (i) the joints?
 - (ii) the muscles or connective tissues?
 - (iii) the back or neck including the cervical and lumbar spine?
- b Is there any evidence of any disorder of the skin?

14 Summary

- a Do you consider any medical attendants' reports or any special tests are required?

(No special tests are to be carried out at AMP's expense without AMP's authority)
- b Do you consider the examinee to be likely to require any surgical operation?
- c Comment fully on any unfavourable features (either physical or mental), which could either reduce life expectancy or cause disablement:-
 - (i) in the personal or family medical history
 - (ii) disclosed by your medical examination

(Please enclose copies of any relevant specialist/hospital reports and/or test results already held)

Payment of Fee

Medical Examiner's Signature

Please Attach Copy of Account to this Form
 Please fill in Name and Address to which cheque is to be sent:
 Name:
 (IN BLOCK LETTERS)
 Address
 Phone

Dated at:
 on
 Signature of Medical examiner
 Qualifications

Important: This Medical Examination is a matter of importance to the person you have just examined and it would be appreciated if you would forward the report without delay to:

Freeport No. 170, The Medical Officer, AMP Life Limited, PO Box 1290, Wellington.

FOR OFFICE USE ONLY

Fee \$ Date Credited / /