momentum

employee benefits

# Personal Statement before a Medical Practitioner

Fund name

Member no. Policy no.

Member Title Initials

First name/s

Surname

Date of birth D D - M M - Y Y Y Y Occupation

Address

Postal code:

Tel No. Cell No.

Email

Medical examiner's name and initials

RSA ID Yes No ID/Passport No.

## 1. Personal Statement

1. Has a proposal/application for assurance for life, health, dread disease, disability or functional impairment insurance ever been declined or deferred or accepted with certain provisions e.g. a higher premium, or any exclusion etc.? Yes No

If yes, state full particulars

## 2. Medical History

Have you ever had, or do you currently have, any of the following?
If yes, state full details of each instance in the schedule following question 2.13

| Question | Yes | No |
|---|---|---|
| 2.1 Disorder of the heart, e.g. rheumatic fever, heart murmur, shortness of breath, palpitations, chest pain or discomfort, or a heart attack? | Yes | No |
| 2.2 High blood pressure, disease of the blood vessels or circulatory disorder e.g. cramps in the calves with exercise or walking, etc.? | Yes | No |
| 2.3 Lung disorders e.g. tuberculosis, asthma, bronchitis, persistent cough or other breathing problems? | Yes | No |
| 2.4 Disorder of the digestive system, stomach, gall bladder, pancreas or liver, e.g. stomach ulcer, recurrent indigestion or heartburn, rectal bleeding, piles or yellow jaundice or have you ever had a gastroscopy or other special examinations? | Yes | No |
| 2.5 Disease or disorder of the kidneys, bladder or sex organs, e.g. abnormal urine test, kidney stones, prostatitis, bladder infections or sexually transmitted disease e.g. hepatitis B, gonorrhoea or syphilis etc.? | Yes | No |
| 2.6 Have you ever sought medical advice, personal counselling or treatment in connection with Aids or HIV infections, blood, urine or saliva testing except for routine insurance tests? If yes please give details. | Yes | No |
| 2.7 Disorders of the nervous system e.g. epilepsy or fits, blackouts or a stroke? | Yes | No |
| 2.8 Mental disorders e.g. depression, anxiety, panic attacks or post traumatic stress disorder? | Yes | No |
| 2.9 Eye, ear, nose or throat disorder, e.g. poor vision, hearing loss, ear discharge, hoarseness? | Yes | No |
| 2.10 Disease or disorder of the skin, muscles, bones, joints, limbs, spine, e.g. any skin rash, rheumatism or arthritis, gout, or any back trouble? | Yes | No |
| 2.11 Sugar diabetes, thyroid or other hormonal or blood disorders, e.g. anaemia, iron deficiency or bleeding tendency? | Yes | No |
| 2.12 Cancer, a growth or tumour of any kind, including moles removed? | Yes | No |
| 2.13 If not already mentioned, have you ever had any other illness, including chronic fatigue (yuppie flu), fibromyalgia, tropical disease (bilharzia or malaria), or have you had any operations, accidents (including motor vehicle accidents) or been hospitalised? | Yes | No |
| 2.14 Have you ever been medically boarded or have you submitted claims for disability or 3rd party benefits? | Yes | No |

## 2. Medical History (continued)

| Question number | Nature, duration and severity of complaint or symptoms | Date | Name and address of attending doctor or hospital | When did you last have symptoms |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 3. For Female Applicants

3.1 Have you ever had or have you now any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or delivery, e.g. abnormal vaginal bleeding, and lumps or cysts of the breasts and ovaries? Yes ☐ No ☐

If yes, give details

3.2 Are you pregnant now? Yes ☐ No ☐ If yes, how many weeks?

3.3 Do you regularly have a pap smear or mammogram? Yes ☐ No ☐

If yes, give details

## 4. Weight/Exercise

4.1 Has your mass altered by more than 5kg over the past year? Yes ☐ No ☐

If yes, has it increased or decreased, by how much, for what reason and for how long has present mass been constant?

4.2 Do you exercise regularly? Yes ☐ No ☐

If yes, state details

5. If not already stated, have you ever:

5.1 had any X-rays, ECGs, other examinations, including genetic testing or tumour markers, operations? Yes ☐ No ☐

5.2 taken any medicines including anti-depressants, tranquillisers or drugs including cannabis (dagga), cocaine, ecstasy, anabolic steroids, etc. for medical or other reasons? Yes ☐ No ☐

5.3 consulted any doctors or any other practitioners e.g. chiropractors, homeopaths, reflexologists, etc. or traditional healers? Yes ☐ No ☐

5.4 Have you ever had any check-ups or insurance medicals? Yes ☐ No ☐

5.5 Are you taking chronic medication for any condition? Yes ☐ No ☐

If yes to any of the above, state details below:

| Exact nature of examinations, consultations and treatment | Date | Name and address of doctor, specialist or hospital | Results of examinations and date of last symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

5.5 Name and address of usual medical attendant:

5.6 How long has he/she has been your doctor?

## 6. Habits **(NB: Momentum Employee Benefits reserves the right to request urine/blood tests for drugs and smoking)**

6.1 What and how much do you smoke per day?

6.2 If you have stopped smoking, state date of change and your previous smoking habits.

6.3 What kind and quantity of alcoholic liquor do you consume: per day / per week

6.4 Have you ever consumed more alcohol on a regular basis, or have you ever been charged with drunken driving? Yes No

If yes, state full details including any treatment.

## 7. Family History

| | If living | | If deceased | |
|---|---|---|---|---|
| | Ages | Give details of past or present health problems | Age of death | Cause of death |
| Father | | | | |
| Mother | | | | |
| Number of brothers | | | | |
| Number of sisters | | | | |

7.2 If not already stated, have any close blood relatives suffered from sugar diabetes, heart disease, cancer, high blood pressure, raised cholesterol, mental illness, or any other hereditary disease? Yes No

If yes, give details

8. Do you take part in any hazardous activities e.g. flying microlight aircraft, motor racing or underwater diving? Yes No

If yes, give full particulars

9. Do you intend seeking medical advice in the next eight weeks? Yes No

If yes, give full particulars

## Declaration by the Member

I declare and warrant that this personal statement is complete and true.
I irrevocably authorise and request any doctor, other person or institution who may be in possession of, or later acquire, any information concerning my health, to disclose it to Momentum Employee Benefits and I agree that this authorisation and request will remain in force after my death.

**Signature of Medical Examiner**

D D - M M - 2 0 Y Y

**Date**

**Signature of Member**

D D - M M - 2 0 Y Y

**Date**

## 10. Medical Examiner's Confidential Report

Please note: In order to avoid any embarrassment, the results of this examination are not to be disclosed to the member or any other unauthorised person. If treatment or investigations are urgently required, please refer the member to his/her personal medical attendant. Please do not arrange for further additional examinations unless prior consent is obtained from Momentum Employee Benefits.

Examination

10. Build and physical condition

10.1 Height(without shoes) [ ] m [ ] [ ] cm Weight(in clothes) [ ] [ ] [ ] kg

10.2 Not needed in case of female member

Chest(insp.) [ ] [ ] [ ] [ ] [ ] (exp.) [ ] [ ] [ ] [ ] [ ] Abdomen [ ] [ ] [ ] [ ] [ ]

10.3 State your impression of the general appearance of the member e.g. flabby, thin, muscular, flushed, etc.)

Are there:

| | | |
|---|---|---|
| 10.4 Any operation scars or skin lesions? | Yes [ ] | No [ ] |
| 10.5 Signs of hyperlipaemia e.g. arcus senilis, xanthomata, xanthelasma, etc? | Yes [ ] | No [ ] |
| 10.6 Enlarged thyroid or lymphatic glands, breast lump or other tumour as per palpation? | Yes [ ] | No [ ] |
| 10.7 Any hernia or varicose veins? | Yes [ ] | No [ ] |
| 10.8 Signs of ear disease? | Yes [ ] | No [ ] |

Describe in detail adverse findings and state whether operative or other treatment is required:

11. Cardiovascular system

11.1 Blood pressure (to be taken in recumbent posture exact reading to be given).
Systolic [ ] mm.Hg
Diastolic [ ] mm.Hg

11.2 If the BP is 140/90, or higher record a second reading, preferably at the end of the examination.
Systolic [ ] mm.Hg
Diastolic [ ] mm.Hg

11.3 State the peripheral pulse [ ]

| | | |
|---|---|---|
| 11.4 Is the peripheral pulse readily palpable? | Yes [ ] | No [ ] |
| 11.5 Are there symptoms and signs of any cardiovascular abnormality, e.g. signs of cardiac enlargement, cardiac failure, murmurs, abnormal heart sounds or arrhythmia? | Yes [ ] | No [ ] |

Describe fully

12. Respiratory system

| | | |
|---|---|---|
| 12.1 Is there any indication of past or present disease? | Yes [ ] | No [ ] |

12.2 Describe fully any abnormality detected such as deficient air entry, abnormal character of breath sounds or adventitious sounds.

13. Gastro-Intestinal system

| | | |
|---|---|---|
| 13.1 Is there any significant abnormality of the mouth or throat e.g. ulcer, tumour, leukoplakia? | Yes [ ] | No [ ] |
| 13.2 Is there any indication of disease of the gastro-intestinal system, liver or spleen? | Yes [ ] | No [ ] |

Describe fully any unhealthy conditions, tenderness, palpable mass or other abnormality detected.

14. Central nervous system

| | | |
|---|---|---|
| 14.1 Is there any significant abnormality of the sight (other than refractive errors) hearing, speech and gait? | Yes [ ] | No [ ] |

14.2 Describe fully any evidence of disease of the central nervous system.

15. Musculoskeletal system

15.1 Are there any signs of joint disease, arthritis, or any abnormalities of the back? Yes [ ] No [ ]

If yes, give details

15.2 Are there any other deformities or physical abnormalities? Yes [ ] No [ ]

If yes, give details

16. Genito-urinary system

16.1 Comment fully on the history of genito-urinary abnormalities. (Rectal or vaginal examinations are not necessary and will be called for only in special circumstances.)

16.2 Urine examination (specimen must be voided in surgery).

16.2.1 Is protein present? Yes [ ] No [ ]

16.2.2 Is glucose present? Yes [ ] No [ ]

16.2.3 Is urobilinogen present? Yes [ ] No [ ]

16.2.4 Is blood present? Yes [ ] No [ ]

16.2.5 Are there any other abnormal findings? Yes [ ] No [ ]

16.2.6 If present, please quantify and give name of test used.

17. General

17.1 Is the member known to you or do you have any special examinations or results of previous examinations? Yes [ ] No [ ]

If yes, give details

17.2 Are you aware of any factor which places the member at risk of infection by HIV/Aids virus or any sexually transmitted disease? Give details including results of any blood tests or other investigations carried out. Yes [ ] No [ ]

17.3 Do you know of or suspect, any other factors regarding past or present health habits(alcohol, tobacco, drugs, etc.) that may influence the member's life expectancy or ability to follow his/her chosen occupation? Yes [ ] No [ ]

Please comment fully

17.4 Would you advise any special examinations (e.g. blood tests, chest X-rays, lung function tests, cardiologist's or neurologist's opinion, etc.) to clarify any points of your examination? Yes [ ] No [ ]

If yes, which examination and why do you advise it?

If additional information is required from your records, Momentum Employee Benefits will specifically request this information and pay the appropriate fee.

IMPORTANT: Please note that the member has authorised us to obtain this information from you (and has instructed you to provide us with this information) and to share it with other life offices directly or through the ASISA for purposes of underwriting and/or other claims assessment. In terms of the ASISA protocol the member may enquire about information held by the ASISA and such information will be made available to him/her through his/her nominated medical practitioner.

I, ______________________ declare that I have taken due and proper care to verify the true identity of
(name of medical practitioner)

______________________ I have inspected the member's:
(name of member)

RSA ID Yes ☐ No ☐ ID/Passport No. ☐☐☐☐☐☐☐☐☐☐☐☐☐

**Signature of Medical Practitioner**

D D - M M - 2 0 Y Y

**Date**

To facilitate payment print your name and postal address below:

DR

PRACTICE NO.

Tel No:

Fax No:

Email:

Name of bank/building society:

Branch office:

Account number: Branch no.:

Account type:

Transmission, cheque, etc

Momentum Employee Benefits will be liable for the account in accordance with the current Momentum rates. Should your rate be higher and/or should any additional investigations be considered necessary, kindly note that these will be for the member's expense. Reports will only be paid on receipt of an account. Please note that if the client does not keep his or her appointment, Momentum Employee Benefits will not be liable for cancellation fees. The cancellation fees must be claimed from the client/employer.

## Send to

The report and account can be sent to our confidential fax line at: 021 940 6136 or
The Senior Underwriter, Momentum Employee Benefits, PO Box 2212, Bellville, 7535 or
emailed to: BAWCTUnderwriting@momentum.co.za