MALDIVES
Allied Insurance Company

# Medical Examiner's Confidential Report

| Full name: | NID no: | Age: | Gender: |
|---|---|---|---|
| Address: | | | |

| Identificaion mark: | Height (cm): | Weight (kg): | Girth of abodomen (cm) over navel: |
|---|---|---|---|
| Chest (cm) (over nipple): | Full expiration (cm): | Full inspiration (cm): | Pulse rate per minute: |
| Systolic blood pressure first reading: | | Systolic blood pressure second reading: | |
| Diastolic blood pressure first reading: | | Diastolic blood pressure second reading: | |

If answer/s to any of the following questions is 'yes' , please give full details

Are there any symptoms and / or signs suggestive of abnormality of the following?

| Question | Yes | No |
|---|---|---|
| Cardio Vascular System? Any degree of severity of Varicose Veins? | ☐ | ☐ |
| Respiratory System? Are there any signs of past or present disease? | ☐ | ☐ |
| Central or Peripheral Nervous System? Are there any signs or symptoms of disease of the Nervous System? | ☐ | ☐ |
| Muscular Skeletal System? Any deformity of bones or joints? Any muscular wasting or other deformity? | ☐ | ☐ |
| Abdomen or Pelvis? | ☐ | ☐ |
| Endocrine Glands? | ☐ | ☐ |

| Question | Yes | No |
|---|---|---|
| Is there any externally visible swelling of lymph glands, joints or other organs? | ☐ | ☐ |
| Is there any abnormality observed on examination of Eyes (partial or total blindness), Ears (deafness), Nose, Throat, or Mouth? | ☐ | ☐ |
| Is there evidence of enlargement of Liver or Spleen? | ☐ | ☐ |
| Is Hernia present? If so please state its situation and whether a truss is worn? | ☐ | ☐ |

For Male LA, Is there any indication of Stricture or Prostatic Abnormality or any other Urinary Tract Abnormality? Yes ☐ No ☐

For Female LA, Is there any disease of the breasts? Yes ☐ No ☐

For Female LA, Do you suspect any disease of Uterus,Cervix or Ovaries? Yes ☐ No ☐

For Female LA, Is there any evidence of pregnancy? If so give duration? Yes ☐ No ☐

Is there any evidence or operation? If so please state: Yes ☐ No ☐

Date of operation ____________ Nature and cause ____________

Location, size and condition of scar ____________ Degree of impairment ____________

Is there evidence of injury due to accident or otherwise? If so please state: Yes ☐ No ☐

Date of injury ____________ Nature of injury ____________

Degree of impairment ____________ Duration of unconsciousness, if any ____________

Has the LA, at any time in the past, undergone any Bio-chemical, Radiological, Cardiological or other tests? If so please give full particulars Yes ☐ No ☐

Has the LA, at any time, suffered from or had symptoms of Diabetes Mellitus and/or Hyper Tension? Yes ☐ No ☐

Have you any reason to suspect that LA is now or has ever been intemperate in the use of alcohol of drugs? Yes ☐ No ☐

Are there other adverse features in habit or health, past or present of LA which you consider relevant? Yes ☐ No ☐

Is there any of following diseases in family of LA? if yes, give details:

Diabetes Yes ☐ No ☐

Psychoneurosis Yes ☐ No ☐

Hereditary disorders Yes ☐ No ☐

Tuberculosis Yes ☐ No ☐

Is there any further evidence, medical or otherwise which you think desirable?

From your examination and enquiries do you recommend that LA should be

| | | | | | |
|---|---|---|---|---|---|
| Accepted at ordinary rates? | Yes ☐ | No ☐ | Re-examined at a later date? | Yes ☐ | No ☐ |
| Accepted at increased rates? | Yes ☐ | No ☐ | Declined? | Yes ☐ | No ☐ |

Declaration: I hereby certify that I have, this day, examined above Life to be assured personally in private and recorded in my own hand true and correct findings and answers to questions as ascertained from the person examined. I declare that the person examined signed (affixed his/her thumb impression) in space earmarked below in my presence and that I am not related to him /her.

Signature of Life to be assured: Date:

Medical Examiner’s name and Address:

Medical Examiner’s qualification:

Medical Examiner’s Signature: Date:

**Note:**
1) Please do not disclose your opinion, whether favorable or otherwise, to the Life to be assured or any other person.
2) This report must be returned by the Medical Examiner DIRECT to Allied Insurance Company or it will be of no avail.