**Transamerica Life (Bermuda) Ltd.**
(Incorporated in Bermuda with limited liability)

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# MEDICAL EXAMINATION

## IMPORTANT INFORMATION

Please complete in ENGLISH and BLOCK CAPITALS.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

Capitalised terms in this form have the same meaning as defined in the Policy.

**Section 1**

☑ Select the box that applies

### (To be completed by the patient )

| | | | |
|---|---|---|---|
| Name | | | |
| Gender | ☐ Male ☐ Female | Date of Birth | (dd/mm/yyyy) |
| ID Type | | ID Number | |

Please provide the following details:

a) Name and Address of Personal or Attending Physician

b) Phone Number — Country Code — Area Code — Phone Number

c) Date last consulted (dd/mm/yyyy)

Reason for consultation

Diagnosis/Result of visit

d) List any medications (prescription or non prescription) you are taking currently

### Smoking Status

1. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? ☐ Yes ☐ No

If 'Yes', provide details below.

| Product | Frequency | Current | Past | Date Last Used |
|---|---|---|---|---|
| Cigarettes | pack(s) day | ☐ | ☐ | (dd/mm/yyyy) |
| Cigars | /day | ☐ | ☐ | (dd/mm/yyyy) |
| Other | /day | ☐ | ☐ | (dd/mm/yyyy) |

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☑ Select the box that applies

## Family Questions

2. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes ☐ No

3. Please provide the following details:

| Living | | | Deceased | | |
|---|---|---|---|---|---|
| | Age | Present Health | | Age | Cause of Death |
| Father | | | Father | | |
| Mother | | | Mother | | |
| Siblings | | | Siblings | | |

## Health Questions

Please provide details for 'Yes' answers in the "Supplementary Information" section below.

4. **Within the last 10 years have you had symptoms of, or been told by a physician that you have had or have:**

a) Chest pain, angina, congestive heart failure, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, heart valve disease or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No

b) Aneurysm, transient ischemic attack (TIA), stroke, or peripheral vascular disease? ☐ Yes ☐ No

c) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? ☐ Yes ☐ No

d) Seizures, fainting, dizziness, epilepsy, convulsions or paralysis? ☐ Yes ☐ No

e) Any nervous, mental or emotional disorder, or received counselling for anxiety, depression, stress, or any other emotional condition? ☐ Yes ☐ No

f) Alzheimer's disease, dementia, memory loss or organic brain syndrome? ☐ Yes ☐ No

g) Multiple sclerosis (MS), muscular dystrophy, Parkinson's disease or tremors? ☐ Yes ☐ No

h) Arthritis, gout, chronic fatigue, fibromyalgia, myalgia, osteoporosis, or any other bone, joint or muscle disorder? ☐ Yes ☐ No

i) Asthma, sleep apnoea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? ☐ Yes ☐ No

j) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach or intestines? ☐ Yes ☐ No

k) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? ☐ Yes ☐ No

l) Anaemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? ☐ Yes ☐ No

m) Disease of the urinary tract, bladder or kidneys, sugar, protein or blood in the urine? ☐ Yes ☐ No

n) Cancer, leukaemia, lymphoma, malignant melanoma or tumours of any kind, malignant or benign? ☐ Yes ☐ No

o) Any other health impairment or medically treated condition? ☐ Yes ☐ No

**Section 1** (Continued)

☑ Select the box that applies

| | | | |
|---|---|---|---|
| 5. | **Within the last 10 years have you had:** | | |
| | a) An operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? | ☐ Yes | ☐ No |
| | b) Any diagnostic tests (e.g. blood, urine, ECGs, x-rays etc), whether conducted on an in-patient or out-patient basis (other than for regular health screening, visa or employment medicals which were confirmed as normal results)? | ☐ Yes | ☐ No |
| 6. | Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? | ☐ Yes | ☐ No |
| 7. | Do you: | | |
| | a) Have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed? | ☐ Yes | ☐ No |

b) Consume alcoholic beverages?

☐ Never

☐ Currently Type of beverage _____ Frequency _____ Quantity _____

☐ In the past Date stopped |_|_|_|_|_|_|_|_| (dd/mm/yyyy) Reason stopped _____

| | | | |
|---|---|---|---|
| 8. | **Within the last 10 years have you:** | | |
| | a) Been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment counselling or participated in a support group? | ☐ Yes | ☐ No |
| | b) Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? | ☐ Yes | ☐ No |
| | c) Used any tranquilizers, sedatives or narcotic drugs or any prescription drug except in accordance with physician's instructions? | ☐ Yes | ☐ No |

## Supplementary Information

| Question Number | Details (include dates, diagnosis, duration, outcome, treatment and the names of all attending physicians, clinics and hospitals) |
|---|---|
| | |

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## Authorisation To Obtain Information

I, _____ (the "patient") hereby consent to and authorise:

1. any registered medical physician, medical practitioner, medical care provider, hospital, clinic, medical laboratory, government organisation or any other medical or medical related facility that has record or knowledge of my health and medical history or treatments to provide such information about me; (including diagnosis, examination and test results, medical reports, treatments and prognosis) with respect to any of my physical or mental conditions and/or treatments to such insurance provider (or its legal representatives) as I may designate from time to time; and
2. the insurance provider (who I have designated) to disclose such medical or other information about me which has been provided to the insurance provider or which the insurance provider develops during its evaluation of any application for life insurance to:
   a) its reinsurers;
   b) any other insurance company that I may designate;
   c) me;
   d) my insurance broker, when that broker is seeking insurance coverage through the insurance provider on my behalf;
   e) any medical professional that I may designate; and
   f) any person or entity entitled to receive such information by law.

I acknowledge and agree that:

1. the above authorisation will be valid for two years from the date shown below. A photocopy of the authorisation will be as valid as the original;
2. the above authorisation shall bind my successors and assigns and remain valid notwithstanding my death or incapacity as far as legally possible;
3. information collected under the authorisation may be used by the insurance provider to evaluate my application for insurance, to evaluate a claim for benefits, for reinsurance or for other insurance related purposes; and
4. I and my authorised representative are entitled to a copy of this authorisation.

## Signatures

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief.

I hereby agree that they shall form part of any application for life insurance for which this medical information was required.

| Signature of **Patient/Proposed Insured** | Signed at | (Country) |
|---|---|---|
| X | Date | (dd/mm/yyyy) |

I certify that I have truly and accurately recorded on this form the information supplied by the patient/proposed insured.

| Signature of **Medical Examiner** as Witness | Print Name of Medical Examiner | |
|---|---|---|
| X | Name of Insurance Intermediary | |

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**Section 2** Medical Examiner's Report

☑ Select the box that applies

## (To be completed by the Medical Examiner)

1. a) Height _____ m/ ft  Did you measure? ☐ Yes ☐ No

   b) Weight _____ kg/ lbs  Did you weigh? ☐ Yes ☐ No

   **Males only: Abdomen _____inches/ cm**

   c) Any weight change in the past 12 months? ☐ Yes ☐ No

   If 'Yes', amount _____kg/lbs

   ☐ Loss

   ☐ Gain

   d) Urine Dipstick Result:

| Protein | Sugar | Blood |
|---|---|---|
| | | |

   ☐ Urine sample sent to the laboratory (please tick)

2. Blood Pressure Readings:

| | Standing | Sitting | Lying |
|---|---|---|---|
| Systolic | | | |
| Diastolic | | | |

3. Pulse

   Pulse Rate : _____ per minute

   ☐ Regular

   ☐ Irregular

   Type of irregularity _____

   If extra systoles, No. per minute _____

4. On examination is/are there any:

   a) Extra or abnormal heart sounds? ☐ Yes ☐ No

   b) Murmurs? ☐ Yes ☐ No

   c) Cardiomegaly or cardiac enlargement ? ☐ Yes ☐ No

   d) Inadequate circulation anywhere? (i.e. shortness of breath, peripheral vascular disease) ☐ Yes ☐ No

   If "Yes" please provide details (Type, Grade, Location)

   _____

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**Section 2** **Medical Examiner's Report (Continued)**

☑ Select the box that applies

| | | |
|---|---|---|
| 5. | On examination, is there any abnormality of the: | |
| | a) Respiratory system? | ☐ Yes ☐ No |
| | b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)? | ☐ Yes ☐ No |
| | c) Eyes, ears, nose, mouth, pharynx, head and neck (including hearing, vision, speech)? | ☐ Yes ☐ No |
| | d) Skin, lymph nodes, peripheral arteries or veins? | ☐ Yes ☐ No |
| | e) Nervous system (including reflexes, weakness, gait, paralysis, tremors)? | ☐ Yes ☐ No |
| | f) Genitourinary system (including prostate, rectum (only if male), external genitalia, breasts)? | ☐ Yes ☐ No |
| | g) Endocrine systems (including thyroid)? | ☐ Yes ☐ No |
| | h) Musculoskeletal system (including spine, joints, amputation, deformity)? | ☐ Yes ☐ No |
| 6. | Have you examined the patient in the past year? | ☐ Yes ☐ No |
| | Is the patient known or related to you and/or your private patient?<br>If 'Yes', please provide details of any medical history which is pertinent to the mortality risk and not already disclosed.<br>_____ | ☐ Yes ☐ No |
| 7. | Describe general appearance (older than stated age, alert?)<br>_____ | |
| 8. | Did anyone accompany the patient during the examination?<br>If "Yes" please provide details<br>Name of the person _____<br>Relationship to Patient _____<br>Why present _____ | ☐ Yes ☐ No |
| 9. | Did the patient understand and answer all the questions asked in connection with this exam?<br>If "No" please provide details<br>_____ | ☐ Yes ☐ No |
| 10. | Do you suspect anything unfavourable such as excessive use of alcohol, cigarettes, or drugs? | ☐ Yes ☐ No |

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**Section 2**

## Medical Examiner's Report (Continued)

**If 'Yes', to any of the above questions please provide details:**

| Question No | Date (dd/mm/yyyy) | Reason & Treatment | Duration of Condition | Name, Address & Phone Number of Attending Physician and Hospital |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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**Section 2** Medical Examiner's Report (Continued)

☑ Select the box that applies

## Medical Examiner's Certification And Signature

How did you identify the patient?

☐ Driver's License (with photo) ☐ Passport ☐ Other photo ID – please provide details

_____

Examination location:

☐ Examiner's Office ☐ Residence of Proposed Insured ☐ Business address of Proposed Insured

☐ Other - please provide details

_____

Indicate requirements completed

☐ Blood ☐ ECG ☐ Urine ☐ TMT ☐ Other

Indicate any requirements not completed and reason

_____

Date provided to the Insurance Intermediary |_|_|_|_|_|_|_|_| (dd/mm/yyyy)

## Signatures

I hereby certify that I have personally examined the patient and have correctly and fully reported my findings.

| Signature of **Medical Examiner** | | Medical Examiner's Stamp/Chop | |
|---|---|---|---|
| X | | | |
| Name of Medical Examiner | | | |
| Place | (Country) | Date | (dd/mm/yyyy) |
| Address | Number/Street/Building | | |
| | City | State/Province | |
| | Country | Postal Code | |
| Phone Number | Country Code – Area Code – Phone Number | | |
| Examination completed on (date and time) | | | |

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