OLDMUTUAL CORPORATE

GROUP ASSURANCE
OLD MUTUAL STAFF
SHORT MEDICAL REPORT

DECLARATION BY THE MEMBER

- I confirm and guarantee that the information in this statement is correct and true.
- I understand that this document forms part of the insurance agreement and that my personal information will be treated in accordance with applicable law, for example it will be safeguarded and treated as confidential.

Accepting that I am thereby curtailing my right to privacy, but to facilitate the assessment and review of my group cover, I authorise Old Mutual

a) to obtain from any medical practitioner, health professional, hospital, employer, insurer or other person who may be in possession of, or later acquire, any information concerning my health, occupation and earnings at their request, and

b) to share this information with other parties, i.e. health professionals, or insurers for the sole purpose of the assessment or review of my insurance cover or a claim.

c) I agree that Old Mutual may ask for additional information via the intermediary or employer.

It is your responsibility to inform Old Mutual of a change in your health status as a result of an illness or injury suffered between the date of this medical and Old Mutual finalising the decision.

Old Mutual will use your information or obtain information about you to verify your identity, for assessment of additional group cover, check claim/medical history on the ASISA Life and Claims register, fraud prevention and detection, market research and statistical analysis, audit and record keeping purposes, and compliance with legal and regulatory requirements.

You may access the personal information that we hold and request us to correct any errors or to delete this information. To view our full privacy notice, please visit our website on www.oldmutual.co.za.

Signature of member

Signature of medical examiner

Place

Date D D M M Y Y Y Y

GUIDELINES FOR COMPLETION

This form, which may be completed by a doctor or nurse, collects information about the medical history and current state of health of a member of group assurance. We need these facts to decide how much additional insurance cover to grant the member.

- Please answer all questions and give as much detail as you can.
- Old Mutual undertakes to pay for the completion of this medical report at ASISA rates.
- Please use block letters in black or blue ink, as it is easier to read.
- Send the completed form to our confidential fax line on 021 509 0731 or email it to: gapstafffund@oldmutual.com

MEMBER'S DETAILS

Scheme code

Surname

First name(s)

Date of birth D D M M Y Y Y Y

Occupation

Telephone at work

Cell number

Email

Home address

Postal code

Confirmation of identity based on ID book or passport.

ID or passport number

Old Mutual Life Assurance Company (South Africa) Limited. Reg No: 1999/004643/06

GAP ASISA Short Medical Report omms 10.2014 L7625

MEDICAL HISTORY

1. Has the member ever been diagnosed with any of these conditions or any related symptoms?

1.1	Any illness of the lungs or airways, e.g. asthma, tuberculosis, chronic bronchitis, persistent cough, etc.	Y	N
1.2	Any illness of the heart or circulation, e.g. chest pain, shortness of breath, raised cholesterol, high blood pressure, coronary artery disease, rheumatic fever, stroke, etc.	Y	N
1.3	Cancer, a tumour or growth of any kind	Y	N
1.4	Any illness of glands or blood, e.g. diabetes, thyroid problems, haemophilia, anaemia, etc	Y	N
1.5	Any illness of the kidneys, bladder or reproductive organs, e.g. protein in urine, kidney stones, prostatitis, sexually transmitted infections, etc	Y	N
1.6	Any complaint of the digestive system, gall bladder, liver or pancreas, e.g. an ulcer, frequent indigestion, hepatitis, rectal bleeding, etc.	Y	N
1.7	Any illness, injury or operation related to the bones, muscles, joints, arms, legs or spine, e.g. arthritis, backache, rheumatism, gout, fractures, etc.	Y	N
1.8	Any psychiatric condition, e.g. depression, anxiety, panic attacks, etc.	Y	N
1.9	Any illness or injury of the brain and nervous system, e.g. epilepsy, blackouts, paralysis, etc.	Y	N
1.10	Any condition of the eyes, ears, nose and throat, e.g. poor vision, hearing loss, etc.	Y	N
1.11	Any skin condition, e.g. psoriasis, eczema, etc.	Y	N
1.12	Any tropical disease, e.g. bilharzia, malaria, etc.	Y	N
1.13	Any other illness, injury, operation, disability or accident.	Y	N

2. Indicate any other medical examination or treatment during the past 5 years.

2.1	Appointments with doctors or other health practitioners	Y	N
2.2	X-rays, ECG's, blood tests	Y	N
2.3	Use of medicine, including sedatives and tranquillisers	Y	N
2.4	Operation or other hospitalisation	Y	N
2.5	Previous medical examination for insurance purposes	Y	N

Please give relevant details for all the "Yes" answers under the medical history section on pages 1 and 2.

Symptom, condition or investigation	Year	Current situation	Attending doctor's name and contact number

For women only

Please record the member's response to the following questions.

Are you pregnant now?	Y	N
If yes, how many weeks?		
Have you ever had any complications during pregnancy, e.g. diabetes or high blood pressure?	Y	N
If yes, please give details		
Have you ever had any condition that affected your breasts, ovaries or uterus?	Y	N
If yes, please give details		
Do you regularly have Pap smears or mammograms?	Y	N
If yes, please give the most recent results		

FAMILY HISTORY

Please indicate conditions such as diabetes, heart disease, cancer, high blood pressure, raised cholesterol, psychiatric illness or any hereditary disease in any close blood relative.

Relationship	Complete if living		Complete if deceased	
	Current age	Note any health problems	Age at death	Cause of death
Father				
Mother				

☐ Number of brothers ☐ Number of sisters

If a brother or sister has a health problem, please state his/her age and condition.

LIFESTYLE

Smoking

Do you smoke?	Y N
If yes, what and how much do you smoke per day?	
If you now smoke **less than before**, or have **stopped** smoking, explain your previous smoking habits and the date it changed.	

Use of alcohol

What kind and quantity of alcoholic drinks do you use per day?	
What kind and quantity of alcoholic drinks do you use on weekends?	
Have you ever been treated for an alcohol problem?	Y N
If yes, please give more information including any treatment.	

Use of drugs

Have you ever used drugs, e.g. cannabis or cocaine?	Y N
If yes, please share what, when and how much.	

Exercise

Do you regularly do physical exercise?	Y N
If yes, what kind of exercise and how often?	
Have you ever taken supplements and/or anabolic steroids?	Y N
If yes, please share what, when and for how long	

General

Have you ever received medical advice to change your lifestyle?	Y N
If yes, what change did he/she recommend and why?	
Have you ever had an HIV test?	Y N
If yes, when was that and what was the result?	
Name of usual doctor or clinic	
Contact number	

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INSURANCE

Do you have individual life or disability insurance?	**Y** **N**
If yes, please give details.	
Has an application for insurance ever been refused or accepted with special provisions?	**Y** **N**
If yes, please give more detail, e.g. has cover been declined or an additional premium charged or a specific condition excluded?	

MEDICAL EXAMINATION

Measurements

Height without shoes	cm	
Weight in clothes	kg	
Measure around waist	cm	
Has your weight changed by more than 5 kg over the last year?		**Y** **N**
If yes, why has your weight changed?		

Cardiovascular system

	Systolic	Diastolic
Blood pressure when lying down		
If the blood pressure is above 140/90, put the member at ease, allow some rest and repeat the reading		
Pulse rate at rest		
Is the pulse rate irregular?	**Y**	**N**
If yes, describe irregularities		

General appearance

Urinary system

Examine a urine specimen obtained at the practice.

	Y	**N**	Comment
Is protein present?	**Y**	**N**	
Is glucose present?	**Y**	**N**	
Is urobilinogen present?	**Y**	**N**	
Is blood present?	**Y**	**N**	

Laboratory tests

Have any samples been taken and forwarded to a laboratory?

Blood	**Y** **N**
Urine	**Y** **N**
Name of laboratory	

MEDICAL EXAMINER DETAILS

Professional details

Signature

Surname

Initials

Date D D M M Y Y Y Y

Qualification

Practice number

Contact details

Telephone

Email

Postal address

Postal code

Are you the member's usual doctor? **Y** **N**

If yes, for how long?

Old Mutual is a Licensed Financial Services Provider

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