

# Medical Examination Report Form - Strictly Confidential

DATE   -   -

### Part A. Personal History to be filled by member

[illegible]

ID/Passport no.

Single ☐ Married ☐

Address

Occupation

Date of birth  -  -  Gender

Email 



 Mobile

2. Have you ever had the following: ( If Yes tick the box)

Sever headaches	<input type="checkbox"/>	Fits or fainting	<input type="checkbox"/>	Gastric or Duodenal ulcer	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Any liver, kidney, bladder complaint or prostate	<input type="checkbox"/>
Any mental or nervous disorder	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>	Skin disorder	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>		

4. Have any of your relatives (parents, brothers, sisters, wife, husband) ever had hypertension, cancer, diabetes or mental illness?

If 'YES' give dates and details. Yes ☐ No ☐

## 5. Habits

What is your daily consumption of :-

a) Tobacco \_\_\_\_\_ b) Alcohol \_\_\_\_\_

### Consent / Declaration

I hereby declare that the above statements are true and complete. I agree that they shall form part of my proposal to be insured by Heritage Insurance Company.

I/We consent to The Heritage Insurance Company Kenya Limited:

- (i) Collecting, using, disclosing and/or processing and/or storing my/our personal data for purposes that are relevant to my policy and as permitted by law;
- (ii) Collecting and sharing my personal data in accordance with the privacy statement on its website (<https://www.heritageinsurance.co.ke/>);
- (iii) Transferring my/our personal data to their reinsurers and affiliated companies for the purposes of insurance and as permitted by law;
- (iv) And /Or its contracted Third parties contacting me via email/phone-call/SMS/post in regard to insurance products and/or services.

I/We hereby declare the truth and correctness of the above statements and agree that this Declaration shall be held to be promissory and the basis of the contract between me/ us and The Heritage Insurance Company Limited.

I/We hereby declare that I have read and understood the provisions of this Form.

No liability (except for the period stated in the Insurer's Official Cover Note) is undertaken until the Proposal is accepted by the Insurer and the premium paid.

[illegible]

Signature: \_\_\_\_\_ Date: 

D	D
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M	M
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Y	Y	Y
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## Part B. Physical Medical Examination to be filled by a Medical Practitioner

### 1. a) Physical examination

Height (cm)	Weight (kg)	BMI
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Doctors observation/ Remarks : \_\_\_\_\_

**b) ECG (Attach report)**

Doctors observation/ Remarks : \_\_\_\_\_

## 2. Cardiovascular System

### a) Blood Pressure

\*If blood pressure is over 140/90 or pulse rate is over 90 please take further blood pressure readings at intervals of 5 minutes.

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

### b) Pulse Rate

c) Are the heart sounds normal? Yes ☐ No ☐

d) Is there a murmur/abnormality in ECG? Yes ☐ No ☐ If 'YES' (Please proceed to do 2D ECHO and attach report)

## 3. Respiratory System

### 4. The skin

### 5. The Ear Nose and Throat

### 6. The Eyes

Visual Equity

### 7. Nervous system

### 8. Abdomen

### 9. Liver

### 10. Spleen

### 11. Urinalysis

### 12. Fasting blood sugar

### 13. HBA1C

### 14. Serum Creatinine

### 15. Is there any defect or deformity of person, enlargement of thyroid or lymphatic glands, or any cicatrices?

### 16. Are there any findings, medical or otherwise, which you think significant?

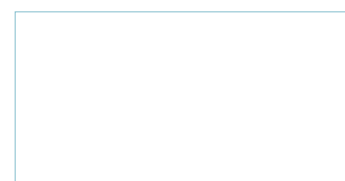
### 17. Are there any further recommended tests for this client

The client is responsible for any further investigations or treatment unless otherwise advised by Heritage in writing.

Doctor's Signature

KMPDC Reg. No

Date     -     -



Rubber Stamp

## PART C. HERITAGE OFFICIAL USE

a) Accepted with cover limitations/sublimits or specific exclusions Yes ☐ No ☐

b) Accepted at ordinary rates? Yes ☐ No ☐

c) Accepted at increased rates? Yes ☐ No ☐

d) Re-examined at a later date? Yes ☐ No ☐

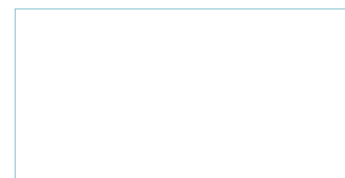
e) Declined? Yes ☐ No ☐

Staff Signature

Date     -     -

*This report is to be treated as strictly confidential and returned to the company under sealed envelope.*

*Any positive findings that have immediate and significant impact on clients health should be discussed with the client.*



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