MEDICAL EXAMINATION FORM (MEF)
CRITICAL COVER EXTRA
CRITICAL ILLNESS INSURANCE RIDER

PACIFIC CROSS

APPLICANT OR PATIENT'S DETAILS

Patient's Name: _____ Date of Birth: ____ ____ ____
Last Name First Name Middle Initial month day year

Addresses:

Residence: _____

Business: _____

Permanent: _____

Contact Details:

Residence Tel. No.: _____ Business Tel. No.: _____

Fax No.: _____ Mobile No.: _____

Email Address: _____

PHYSICIAN'S EVALUATION REPORT

Please complete the following questionnaire accurately, in accordance with your knowledge, the past records of the patient, as well as the results of your interview and complete physical examination. For each YES answer, please provide details on the space provided on the next page.

PART I: Personal Statement of Medical History (to be completed by the Physician)	YES	NO
1. Are you the patient's attending physician?	❑	❑
2. If Yes, for how long have you been the patient's attending physician? Date Last Consulted: _____ *If not, please give details of the Attending Physician:* Name of Physician: _____ Address: _____ Date Last Consulted: _____ Reason of Consultation: _____		
3. Do the looks or appearance of the patient indicate any weakness or sickness, including mental illness? If Yes, please give details on the space provided on the next page.	❑	❑
4. Has the patient ever smoked? If Yes, please complete the following questions. **a)** If the patient already quit smoking, when was the last time he smoked? _____ **b)** If the patient is still a smoker, when did he start smoking? _____	❑	❑
5. Does the patient drink alcohol? If Yes, please state: Kind _____ Amount _____ Frequency _____	❑	❑
6. Has the patient used habit forming drugs or narcotics, or been treated for alcoholism or drug habit? If Yes, please give details on the space provided.	❑	❑
7. Has the patient had, or been treated for, or does the patient plan to investigate (For "YES" responses, please provide details on the space provided on the next page.):		
a) Chest pain, palpitation, abnormal blood pressure, rheumatic fever, heart murmur, cholesterol and/or triglycerides, heart attack or other disease of the heart or blood vessels?	❑	❑
b) Allergies, anaemia, haemophilia or other disease of the blood?	❑	❑
c) Indigestion, ulcer, colitis, jaundice, hepatitis, diverticulitis, hernia, haemorrhoids, or other disease of the stomach, intestines, liver, gall bladder, pancreas spleen or been found to be a Hepatitis B carrier?	❑	❑
d) Sugar, albumin, blood or pus in urine, renal colic or other disease of the kidneys, bladder, prostate, reproductive organs or breasts?	❑	❑
e) Diabetes, thyroid, pituitary, adrenal or other glandular disease?	❑	❑
f) Blood spitting, tuberculosis, asthma, persistent cough, pleurisy, or any other respiratory or lung disease?	❑	❑
g) Cancer, tumour, cyst, disease of the skin or lymph gland?	❑	❑
h) Epilepsy, fainting spells, seizure, nervous or mental conditions, neuritis, paralysis or any disease or abnormality of the brain or nervous system?	❑	❑
i) Arthritis, gout, sciatica, injury or disease of the muscles, bones or joints including the back and neck?	❑	❑

	YES	NO
j) Disease of eyes, ears, nose or throat?	❑	❑
k) Any sexually transmitted disease?	❑	❑
l) Any other disease, illness, injury not stated above?	❑	❑
8. Has the patient ever (For "YES" responses, please provide details on the space provided.):		
a) Had any tests to detect the presence of AIDS or HIV antibodies?	❑	❑
b) In the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions?	❑	❑
c) Had a blood transfusion or been refused as a blood donor?	❑	❑
9. In the past five (5) years (For "YES" responses, please provide details on the space provided.):		
a) Had any medical examinations, advice, hospital treatment or operations?	❑	❑
b) Had any tests such as electrocardiogram, X-ray, echo or ultrasonogram, blood or urine studies?	❑	❑
10. For Females only:		
a) Has the patient ever had any disease of the breast or female organs or complications at childbirth? If Yes, please provide details on the space provided.	❑	❑
b) Is the patient now pregnant? If "yes", please state expected delivery date._____	❑	❑
11. Has any near relative suffered from heart disease, high blood pressure, stroke, coronary artery disease, epilepsy, cancer, diabetes, kidney disease, liver cirrhosis, mental disorder, tuberculosis or any hereditary disease? (If "yes", please give details below.)	❑	❑

Family History	Father	Mother	Brother (s)	Sister (s)
Living (Y/N)				
Age/Current Health				
Deceased (Y/N)				
Age at Death/ Cause of Death				

DETAILS OF YES RESPONSES **If space is insufficient, please attach additional details.**

Qstn No.	Diagnosis & Date	Type & Duration of Treatment	Date of Re-attack (state "nil" if no re-attack)	Current Condition & Follow-up Treatment	Doctor's Current Info (Address, Phone No., Fax No.)

PART II: Physician's Report

	YES	NO
1. Are there any abnormalities in any of the following? **a)** Head, oral cavity, throat	❑	❑
b) Eyes	❑	❑
c) Ears (external/internal)	❑	❑
d) Thorax	❑	❑
e) Lungs	❑	❑
f) Cardiovascular system	❑	❑
g) Abdomen	❑	❑
h) Spinal Column	❑	❑
i) Arms, legs or feet (varicosity, edema, peripheral pulse, indications of existing or previous phlebitis, muscular atrophy, joint deformities, etc.)	❑	❑
j) Skin or lymph glands	❑	❑
k) External sexual organs or breasts	❑	❑
l) Nervous system (in particular paralysis, tremors, abnormal reflexes)	❑	❑

For YES responses, please provide details below (If space is insufficient, please attach additional details.)

Qstn No.	DETAILED DESCRIPTION (including dosage and consumption of medicine if applicable)	Nature/Date of Treatment	Current Status

2. **a)** Blood Pressure

Systolic	_____ mmHg	_____ mmHg	_____ mmHg
Diastolic	_____ mmHg	_____ mmHg	_____ mmHg

(If over 140 systolic or 90 diastolic or with history of hypertension, two further readings at 5 to 10-minute intervals are required.)

b) What is the rate and character of the pulse? Pulse rate: _____ per minute Character: _____

c) What is the position of the apex beat of the heart? In the _____ intercostal space _____ cms to the left of midsternal line.

d) Is there any evidence of cardiac enlargement? ❑ YES ❑ NO
If "yes", please give details. _____

e) Is there any abnormality in the heart sounds or rhythm? ❑ YES ❑ NO
If "yes", please give details. _____

f) Is there any murmur? (If murmur is present, describe fully including site, timing, intensity and transmission.)

Grade _____ Timing: ❑ Systolic ❑ Diastolic ❑ Presystolic ❑ Pansystolic
Intensity: ❑ Soft ❑ Moderate ❑ Loud

Location _____ Transmission: ❑ None ❑ Axilla ❑ Scapula
After exercise: ❑ Absent ❑ Decreased ❑ Unchanged ❑ Increased

g) Is there any abnormality in the heart or vascular system? ❑ YES ❑ NO
If "yes", please give full details. _____

LIST OF MEDICAL TESTS REQUIRED

NOTES: 1. Tests required will vary depending on the applicant's age and Sum Insured for Critical Cover Extra.
2. Please attach all original copies of relevant results.
3. The cost of required medical tests based on the standard list below may be reimbursed by the applicant from Pacific Cross except when the former did not push through with the application. The cost of additional tests required by Pacific Cross on top of the standard list is to be paid by the applicant.

STANDARD LIST		
FOR SUM INSURED *$25,000 ages 50-55 years old:* • Complete Blood Count (CBC) • Urinalysis • Electrocardiogram (ECG) • Fasting Blood Sugar (FBS) • Chest X-ray (CXR) PA Lateral • Total Cholesterol • Ultrasound (Liver)	**FOR SUM INSURED *$50,000 ages 46-49 years old:*** • Complete Blood Count (CBC) • Urinalysis • Electrocardiogram (ECG) • Fasting Blood Sugar (FBS) • Chest X-ray (CXR) PA Lateral • Total Cholesterol • Ultrasound (Liver)	**FOR SUM INSURED *$50,000 ages 50-55 years old:*** • Complete Blood Count (CBC) • Urinalysis • Treadmill Stress Test (TMST) • Fasting Blood Sugar (FBS) • Chest X-ray (CXR) PA Lateral • Total Cholesterol • Ultrasound (Liver)
Additional: _____ _____	**Additional:** _____ _____	**Additional:** _____ _____

3. Complete Blood Count (CBC) result: _____

_____

4. Urinalysis result:
Protein _____ Blood _____ Sugar _____

5. Electrocardiogram (ECG) result: _____

6. Fasting Blood Sugar (FBS) result: _____

7. CXR PA Lateral result: _____

_____

8. Total Cholesterol / Lipid profile result:
Total Cholesterol _____ LDL_____ HDL _____ Triglyceride _____

9. Treadmill Stress Test (TMST) result: _____

10. Ultrasound (Liver) result: _____

11. Date of examination (day/month/year) _____

I hereby declare that the statements and answers concerning the patient are complete and true, that they are correctly and fully recorded and that no material information has been withheld or omitted concerning his/her past and present state of health and habits of life. I agree that this declaration shall form part of the Application for Insurance on the life of the patient made to Pacific Cross Insurance, Inc.

Dated at _____ on _____ day of _____ 20 _____.
(Clinic Address) (Day) (Month) (Year)

Signature of Doctor:_____ Signature of Patient:_____

Printed Name of Physician:	PTR No.:	License No.:
Hospital/Clinic:		
Hospital/Clinic Address:		
Clinic Hours:	Clinic Tel. No.:	
Mobile No.:	Email Address:	

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You may request additional copies of this Medical Examination Form from our Medical Sales Representatives.