



Confidential

AXA Customer Service Centre
PO Box 14330, Melbourne VIC 8001
Telephone 132 987 Facsimile 1800 674 684

Entered in Medical Fees Register
Initials Date
Name of financial adviser arranging the examination AXA reference

This form must be posted to AXA Australia's Customer Service Centre upon completion of this examination

Title Surname (use block letters) Given name(s)

Address of person to be insured or name of superannuation fund (if applicable)

Date of birth

State fully the industry in which you are employed and the type of work in your profession, trade or business.

Industry Type of work

Personal statement by the person to be insured

To be completed at the time of the medical examination, however, sections A to C will not be required when the following criteria have been met:

- Medical examination completed by a fully qualified doctor
A copy of the fully completed personal statement from the application form is presented with this medical examination form to the doctor and remains attached, and
The doctor signs the following declaration stating that the personal statement has been sighted.

I declare that I have sighted a copy of the personal statement from the application for insurance for the person to be insured.

Signature of medical examiner Date

Questions relating to the person to be insured

The medical examiner is requested to ensure that a clear and complete answer is given to each of the following questions.

A Habits

1 (a) Have you ever been a smoker or used any sort of tobacco products?

No
Yes
Cigarettes Tobacco pipes Cigars Nicotine replacement products
Other
On average, how many do you or did you smoke daily?
If you have stopped, when?

(b) Have you ever been advised by a health care professional to reduce your smoking because of a medical condition?

If yes, please advise the name of the condition and any treatment received:
Condition Treatment

2 How many standard drinks containing alcohol do you consume per week on average?
[standard drink = 1 nip spirits, 100ml wine, 10oz/285ml beer] standard glasses per week

Medical examination report (continued)

- 3 Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? No Yes

If yes, please advise your alcohol intake amount at that time, reason you were advised and details of any treatment:

- 4 Do you or have you ever used recreational drugs or drugs not prescribed by a doctor? No Yes

If yes, please give details, including the type of drug and the date(s) used:

B Medical history

- 1 (a) What is your: Height Weight

(b) Has your weight varied in the last 12 months? No Yes

If yes, please tick one of the following and provide the amount and the reason: Gain Loss

Amount (kgs) Reason

- 2 At any time in your life have you **ever** suffered from, received advice for, or experienced symptoms of the following (**even if you have not seen a doctor**):

- (a) No Yes Back or neck disorder including slipped disc, sciatica or whiplash
- (b) No Yes Disorder or injury of the joints including arthritis or gout (eg a disorder or injury of the ankle, elbow, hip, knee, wrist or shoulder)
- (c) No Yes Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis)
- (d) No Yes Nervous disorder or mental illness (eg depression, anxiety, stress, insomnia, post-natal depression or post traumatic stress disorder)
- (e) No Yes Chronic fatigue or chronic pain syndrome
- (f) No Yes Fibromyalgia, fibrositis or myalgia
- (g) No Yes Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury
- (h) No Yes Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy
- (i) No Yes Epilepsy, fit or blackout, migraine or recurrent headaches
- (j) No Yes Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face
- (k) No Yes High blood pressure or raised cholesterol (including being advised to take medication or have your levels monitored)
- (l) No Yes Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain
- (m) No Yes Disorder of the blood including anaemia or haemophilia
- (n) No Yes Asthma
- (o) No Yes Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder
- (p) No Yes Disorder of the thyroid
- (q) No Yes Diabetes, sugar in the urine or raised blood sugar levels
- (r) No Yes Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones
- (s) No Yes Disorder of the digestive system, gall bladder, stomach, bowel or liver including hepatitis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, hernia or irritable bowel syndrome
- (t) No Yes Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision)
- (u) No Yes Disorder of the ears or speech including hearing loss or tinnitus
- (v) No Yes Disorder of the skin including psoriasis, eczema or dermatitis
- (w) No Yes Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or skin cancer or any malignant condition
- (x) No Yes Cyst, skin lesion, growth, lump (including breast lump), mole or freckle that has bled, become painful, changed colour or increased in size
- (y) No Yes Any sexually transmitted infection or disease

Males only

- (i) No Yes Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or undescended testicle?

Females only

- (ii) No Yes Are you currently pregnant? If yes, please advise expected delivery date
- (iii) No Yes Have you ever had any complications with pregnancy or childbirth? If yes, please provide details below, including whether resolved after delivery.
- (iv) No Yes Have you ever had an abnormal breast ultrasound, mammogram or investigation?
- (v) No Yes Have you ever had an abnormal cervical pap smear or biopsy of the cervix or uterus?

If you answered 'Yes' to any of the items in question 2, please provide full details in the table overleaf.

Medical examination report (continued)

Item No. eg (f)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
	/ /				%
	/ /				%
	/ /				%
	/ /				%
	/ /				%
	/ /				%

3 Other than what you have already mentioned in this form, have you in the last **five years** (not including colds or flu):

- (a) No Yes Attended any other medical appointment (eg counselling), or had any other test (eg x-ray, blood, genetic) with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists?
- (b) No Yes Used or currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition?
- (c) No Yes Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than three consecutive days?

If you answered 'Yes' to any of the items above, please provide details in the table below.

Item No. eg (b)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery %
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%

4 Other than what you have already mentioned in this form:

- (a) Have you ever been admitted to hospital for any reason? ▶ No Yes
- (b) Are you experiencing any symptoms or complaints for which you have not consulted a doctor? ▶ No Yes
- (c) Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery? ▶ No Yes

If you answered 'Yes' to Q4 (a), (b) or (c) above please provide details:

Medical examination report (continued)

- 5 (a) Do you or any of your current or previous sexual partners have HIV/AIDS, or any sign of HIV infection? ▶ No Yes
 For example some signs are: unexplained weight loss, swollen glands or persistent diarrhoea.
- (b) In the last three years are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? ▶ No Yes
 HIV risk situations include but are not limited to: sex with or as a prostitute, sex with an intravenous drug user, contact with someone else's blood (for example through injection or scratch with a used needle), anal intercourse (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).

C Family history

Has either one of your parents, brothers or sisters suffered from heart disease, stroke, high blood pressure, diabetes, breast cancer, bowel cancer, other cancer, polycystic kidney disease, Huntington's Chorea, inherited blood disease, inherited brain disease, kidney failure, muscular dystrophy, or any other inherited disease? ▶ No Yes

If yes, please provide details in the table below:

Direct family member (please state their relationship to you but not their name)	Condition/illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)

Declaration – to be completed in all instances

I declare that my answers to the questions in the Personal statement are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written in by me or by another person on my behalf. I understand that the Plan will be issued upon faith in the correctness of these answers.

Signature of* (delete one): *Person to be insured, *Parent/Guardian of child life to be insured

Date

X

 / /

Signature of medical examiner

X

Medical examination report (continued)

Confidential medical report to the insurer

On the medical condition of

Note: Information regarding your findings should NOT be given to any other person. Exception may be made, subject to the examinee's consent, if in your opinion there is medical information which should be conveyed to his/her medical attendant. The Company's decision concerning the proposal for insurance will be based on a careful consideration of the medical evidence and other factors, including the type of insurance sought. The EXAMINER is therefore requested NOT to express to the examinee any opinion concerning the examinee's insurability.

D Introduction

- 1 Are you acquainted with the examinee? ▶ No Yes
If yes, please give details:
(a) Professionally? years
(b) Personally? years
- 2 Is there anything unfavourable in appearance, development or behaviour? ▶ No Yes
If yes, please give details:
- 3 Is there any indication of past or present abuse of alcohol or of misuse of drugs? ▶ No Yes
If yes, please give details:
- 4 Are there any scars? ▶ No Yes
If yes, please give details:

E Measurements

Give the following measurements:

- 1 Height (without shoes) cm
- 2 Weight (clothed) kg
- 3 Abdomen at umbilicus (next to skin) Abdomen cm
- 4 Chest (next to skin) Chest expiration cm Inspiration cm
- 5 If chest expansion is less than 5cm comment as to the apparent cause:

F Respiratory system

- 1 Is there any abnormality of the respiratory system to palpitation, percussion or auscultation? ▶ No Yes
Comment fully on abnormalities:

G Circulatory system

- 1 What is the rate and character of the pulse? Pulse rate per min Character
- 2 What is the position of the apex beat of the heart? In the interspace, cm from the mid-sternal line.
- 3 Is there any evidence of cardiac enlargement? ▶ No Yes
If yes, please give details including cause where applicable:
- 4 Is there any abnormality in the heart sounds or rhythm? ▶ No Yes
If yes, please give details including cause where applicable:
- 5 Is any murmur present? If yes, describe fully including site, timing, intensity, transmission and cause. Also indicate any effect of posture or respiration on the murmur. ▶ No Yes

Medical examination report (continued)

6 What is the blood pressure? (Auscultatory method) The diastolic level is to be taken at the cessation of all sound. If the first systolic reading is above 135 or below 100, or the diastolic above 85 or below 60, two further readings at 5 to 10 minute intervals are required. The recumbent position should be used where possible.

	Examination readings		Repeat readings only		Date
1st reading	<input type="text" value=" "/>		1st reading	<input type="text" value=" "/>	<input type="text" value=" "/>
2nd reading	<input type="text" value=" "/>		2nd reading	<input type="text" value=" "/>	
3rd reading	<input type="text" value=" "/>		3rd reading	<input type="text" value=" "/>	

7 Is there any abnormality of the peripheral arterial or venous circulation? ▶ No Yes

If yes, please give details including cause where applicable:

8 Is there any abnormality of the heart or vascular system? ▶ No Yes

If yes, please give details including cause where applicable:

9 Is the examinee now on treatment for hypertension? ▶ No Yes

If yes, and if you have the required information, please state

(a) Pre-treatment blood pressure level including date(s)

(b) Duration of treatment, and

(c) Nature of treatment

H Digestive and lymphatic systems

1 Is there any abnormality of tongue, mouth or throat? ▶ No Yes

If yes, please give details including cause where appropriate:

2 Is there any abnormality or evidence of disease of any abdominal organ, including liver and spleen? ▶ No Yes

If yes, please give details including cause where appropriate:

3 Is there any abnormality of lymph nodes in the neck, axillae or inguinal regions? ▶ No Yes

If yes, please give details including cause where appropriate:

4 Is a hernia present? ▶ No Yes

If so, describe fully:

I Genito-urinary system

1 Examination of the urine. If (a), (b) or (c) is found (including traces) AND if it was an early morning specimen, please perform MSU (micro-urine) and attach results. If it was NOT an early morning specimen, please arrange an early morning specimen and if (a) (b) or (c) is found (including traces) AGAIN, then please perform MSU (micro-urine) and attach results. If client is a diabetic please do not perform MSU (micro-urine). If client is female please perform MSU (micro-urine) after 7 days.

(a) Albumin (b) Glucose (c) Blood MSU conducted and results attached

2 Is the client menstruating? ▶ No Yes

3 Is there any evidence of abnormality of the genito-urinary system? ▶ No Yes

If yes, please give details including cause where appropriate:

J Females only

1 Is the examinee pregnant? ▶ No Yes

If so, give expected date of confinement:

2 Is there any abnormality of the breasts? Breast examination is desirable but the examiner is asked to exercise sensitivity and discretion. ▶ No Yes

Please state if not examined:

3 Date and result of last cervical cytology (if known):

Medical examination report (continued)

K Nervous system

1 Is there any defect of vision or abnormality of the eyes? ▶ No Yes

2 Is there any defect in hearing or speech? In cases of present or past ear discharge or deafness, state result of auriscopic examination. ▶ No Yes

3 Is there any evidence of:

(a) mental abnormality? ▶ No Yes

(b) any disorder of the central or peripheral nervous system? ▶ No Yes

L Musculo-skeletal system and skin

1 Is there any abnormality of:

(a) the joints or limbs? ▶ No Yes

(b) the muscles or connective tissues? ▶ No Yes

(c) the back or neck including the cervical and lumbar spine? ▶ No Yes

2 Is there evidence of any disorder of the skin? ▶ No Yes

M Summary

1 Do you consider any medical attendant's reports or any special tests are required? ▶ No Yes
(No special tests are to be carried out in connection with the proposal for insurance without the Insurer's authority.)

2 Do you consider the above-named person to be predisposed to any particular ailment or likely to require surgical operation? ▶ No Yes

3 Comment fully on any unfavourable features which may affect either the death or disablement risk:

(a) in the personal or family medical history? Comment:

(b) disclosed by your medical examination? Comment:

Dated at am/pm on / /

Signature of medical examiner

Qualification

Printed name

Name and address for payment of fee
