G.U.T GROUP MEDICAL PLAN
MEDICAL EXAMINATION FORM

Part 1 Applicant's Statement to the Medical Examiner

Name of Applicant: _____

1. Date of Birth? _____ **2**. Your present Occupation? _____ **3**. Are you in sound health as far as you know and believe? _____

4. Have you ever changed or been advised to change residence or occupation for benefit of your health? If so, give details. _____

5. Have you ever used alcoholic beverages to excess or intoxication? If so, give details. _____

6. To what extent do you use alcoholic stimulants now? _____

7. (a) Have you smoked cigarettes within the last 12 months ____ (**b**) Have you used tobacco products within the last 10 years? ____ **(c)** If yes, state type of product and \ average daily use _____

8. (a) Have you ever used morphine, cocaine or any narcotic drug?___ **(b)** Are you presently using any type of drug? If so, give details. _____

9. Have you ever been rejected, rated up or postpone by any insurance company? If so, specify the action taken and the date and name of company. _____

10. Have any member of your family ever had tuberculosis or have you at any time been associated with a person having this disease? If so, give full details. _____

11. Have you ever been refused for or discharged from military or naval service for physical reasons? If so, state which and give date and reason. _____

12. Have you ever applied for or received compensation or disability benefits from the government or any insurance company? If so, give amount, dates and reason. _____

13. (a) Has your weight changed in the past year? If so, give details. _____ **(b)** Do you exercise regularly? If so, how often. _____
(c) Do you often feel run down and extremely tired? _____

14. Have you had any blood transfusions recently?____ **15**. Have you ever had any of the following diseases or symptoms? Each must be read and answered **yes or no.**

(a) Apoplexy, fits, epilepsy, nervous breakdown, frequent headaches, fainting spells, fever, sweating, meningitis or any disorder of the nervous system. _____

(**b**) High or low blood pressure, palpitation, heart disease or any disorder of the circulatory system? ____ **(c)** Asthma, pleurisy, chronic cough, pneumonia, tuberculosis, bronchitis, influenza or any disorder of the respiratory system? _____ **(d**) Appendicitis, gastritis, dyspepsia, gastric or duodenal ulcer, jaundice, fistula, hernia, diarrhea, abdominal colic, hepatitis or any disorder of the digestive system or abdominal organs? _____ **(e)** Kidney trouble, syphilis, gonorrhea, herpes, albumin, casts, or sugar in urine or any disorder of the genitor- urinary system? ____ **(f**) Lumbago, sciatica, rheumatism, arthritis, paralysis, enlarged veins, skin disease, goiter, tumor, cancer, dysphagia or lymphadenopathy? ____ **(g)** Impairment of eyes, ears or limbs or any physical defect or deformity? ____ **(h**) Have you within the past five years had any illness or consulted a physician for any reason not included in your previous answers? _____

*In regard to those answered **YES** give full details below:*

Disease, Injury or Operation	# of Attacks	Date of last Attack	Duration	Severity	Results	Name & Address of Physician

I hereby declare that the above answers are full, complete and true and I agree that they are to be considered the basis of any insurance issued heron.
I hereby authorize any physician at any time to furnish information he\she may be in possession of regarding me.

Dated at _____ **this** _____ **day of** _____

Witness _____ _____
Medical Examiner ***Signature of Applicant***

16. Family Record

	Living		DEAD		
	Age	**Health**	**Age**	**Date of death**	**Cause of death**
Father					
Mother					
Brothers					
Sisters					
Children					

17. Do you have periodical health examinations? **Yes \ No** When last? _____ Findings _____ By Whom? _____

18. Have you ever undergone surgical operations? **Yes \ No** Date of Operation _____ Nature of Operation _____

19. Name of doctor you last consulted? _____ **Date** _____ **Address** _____

Why consulted _____ **Results** _____

20. **FOR ADULT FEMALES ONLY** Have you ever had any type of female disease or trouble? **Yes \ No** Are you pregnant? If so give months advance. _____

Have you passed the climacteric? **Yes \ No** Have you ever had a miscarriage or difficulty in labour? **Yes \ No** If so, give date and details _____

If married, give maiden name _____ Amount of insurance husband carries in your favour? _____

Are you now or have you ever been involved in prostitution? **Yes \ No** Have you ever had, sought consultation for, been tested for, treated for or told that you have AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex) or any immunological disorder. **Yes \ No**

21. **FOR ADULT MALES ONLY**

Are you presently involved or have you ever been involved in any homosexual or bisexual relationship? **Yes \ No** Have you ever had, sought consultation for, been tested for, treated for or told that you have AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex) or any immunological disorder? **Yes \ No**

PART II MEDICAL EXAMINER'S REPORT

22. Are you related to the applicant or agent?____ **23.** How long have you known applicant? _____ **24**.What is applicant's apparent age? _____

25. Dose applicant's appearance indicate good health?_____ **26. BUILD** (a) Height with shoe on? ___ft ___ins **(b)** Weight with clothes on? ___lbs

(c) Girth of abdomen at umbilicus? ___ins **(d**) Girth of Chest (expiration)? ___ins **(e)** Girth of chest (inspiration)? ___ins **(f**) Did you measure applicant? **Yes or No**

(g) Did you weigh applicant? **Yes or No**

27. **TEMPERATURE** (Full minute under tongue) _____ **28. BLOOD PRESSURE** (If over 145 systolic or 90 diastolic, please retake later in examination and report second reading under "Explanatory Remarks") **Systolic** _____**mm Diastolic** _____**mm**. 5th phase (Disappearance of sound)

29. Pulse (Describe any intermittencies or irregularities under "Explanatory Remarks"

	Rate per minute	**# of irregularities**
a) Per full minute seated at rest	_____	_____
b) Immediately after 15 vigorous bends	_____	_____
c) Three minutes after exercise	_____	_____

30. **HEART (a**) Are sounds and rhythm normal? _____

(b) Is there a murmur present? ____ If so, state location _____

Systolic or Diastolic? _____ Is murmur transmitted?_____

Effect of exercise _____ **(c)** Is there any enlargement of the heart? _____ If so, state the degree of hypertrophy_____

(d) Diagnosis of the condition of the heart

31. LUNGS. Are the respiratory sounds normal in all areas with no evidence of related dullness or other pathology? _____

32. ABDOMEN. Is there any evidence of tenderness, masses or other pathology developed by palpation or pressure over liver, spleen, region of appendicitis, gall bladder, kidneys or abdomen? _____

33. URINALYSIS. Specific Garvity? _____ Reaction?_____ Albumin? _____ Sugar? _____ _____

Specimen voided at _____**p.m. \ a.m.** on _____ date.

NOTE: A specimen should be sent to the Home Office at all ages when there is any evidence past or present of cardiovascular disease or urinary impairments. Regardless of history or finding a specimen should be sent at ages 55 and over, or at any age if the amount applied for is 4,000 or more.

Are you sending a specimen for Home Office urinalysis? _____

34. Are there any indications of disorder of:

EXPLANATORY REMARKS:

a)	Brain or Nervous System (Test papillary and patellar reflexes)	YES or NO _____
b)	Respiratory Organs (Throat, Nose, Sinuses)	YES or NO _____
c)	Glands (Thyroid, Lymph, Endocrine, etc.)	YES or NO_____
d)	Blood Vessels (Arteriosclerosis, varicosities, etc.)	YES or NO_____
e)	Skin, Muscles, bones, Joints (Deformity, Rheumatism, etc.)	YES or NO_____
f)	Ears or Eyes (Deafness or discharge from ears, impaired eyesight)	YES or NO_____
g)	Hernia? (If so, state location, size and whether reducible)	YES or NO_____
h)	Any other part of the body.	

35. SUMMARY

Give a summary of medical history and physical findings which in your opinion might affect longevity _____

_____

_____

I certify that I have carefully examined _____ **of** _____

in private at _____**(Home, doctor's Office, etc.) on the** _____ **day of**_____**20**_____

_____ _____

Examiner's Signature **Examiner's Post Office Address**