CHUBB®

Chubb Life

บริษัท ชับบ์ ไลฟ์ แอสชัวรันซ์ จำกัด (มหาชน)
ทะเบียนเลขที่ 0107555000431 เลขประจำตัวผู้เสียภาษี 0107555000431
130-132 อาคารสินธร ทาวเวอร์ 3 ชั้น 21-22 ถนนวิทยุ แขวงลุมพินี เขตปทุมวัน กรุงเทพฯ 10330
โทร. 1283 โทรสาร 0-2675-3818 www.chubb.com/th

MEDICAL EXAMINER'S REPORT (HC2)

(To be used only in case of Insured or Payer age of 16 years and more)

PART 1 EXAMINATION OF ADULT (This examination should be made in private. No third person should be present)

Full name of Insured or Payer Male ☐ Female ☐	Height (cms) in low shoes	Chest (Force inspiration)	Abdomen (At umbilicus)
	Weight (kgs) without coat	Chest (Force expiration)	

If the answer is "Yes", Please identify more of details

1. A. Are you personally or professionally acquainted with the Insured or Payer? If so, how long? ☐ No ☐ Yes.....
   B. Is appearance unhealthy or older than stated age? ☐ No ☐ Yes.....
   C. Is there any reason to suspect intemperate habits? ☐ No ☐ Yes.....
   D. Are there any identification marks (such as scars, birthmarks etc.)? ☐ No ☐ Yes.....

2. Do you find any evidence of past or present disease or abnormality? of :
   A. Central or peripheral nervous system (including reflexes, gait, paralysis)? ☐ No ☐ Yes.....
   B. Respiratory system (lungs, pleura, chest wall)? ☐ No ☐ Yes.....
   C. Abdomen (including stomach, liver, spleen, hernias)? ☐ No ☐ Yes.....
   D. Genito-urinary system? ☐ No ☐ Yes.....
   E. Thyroid or other endocrine glands or metabolic and haemopoietic systems? ☐ No ☐ Yes.....
   F. Eyes, ears, nose, throat and mouth (including-impairment of sight or hearing)? ☐ No ☐ Yes.....
   G. Skin, bones or joints (including varicose veins deformities, lameness, amputations)? ☐ No ☐ Yes.....

3. BLOOD PRESSURE (If over 140 systolic or 90 diastolic record 3 readings)

Systolic			
Diastolic (5th phase)			

4. PULSE

	At Rest	After Exercise	3 Minutes Later
Rate Per Minute			
Irregularities Per Minute			

Exercise only if irregular pulse, heart murmur or BP over 150/100

5. HEART: Apex Beat located at.....intercostal space.....inches to the left of MIDCLAVICULAR line. Is there any
   A. Arteriosclerosis or aneurysm? ☐ No ☐ Yes.....
   B. Hypertrophy or oedema? ☐ No ☐ Yes.....
   C. Murmur ☐ No ☐ Yes (If murmur is present, describe below)
   Location: ☐ apex ☐ base-over.....Area
   Timing: ☐ systolic ☐ diastolic ☐ presystolic
   Intensity: ☐ soft ☐ moderate ☐ loud
   Transmission: ☐ none ☐ axilla ☐ scapula
   After exercise: ☐ absent ☐ decreased ☐ unchanged ☐ increased
   Diagnosis:.....
   Do you suspect any abnormality in the heart or vascular system?

6. URINALYSIS : pH	Specific gravity	Albumin	Sugar	Blood

Send for microscopic urinalysis if:
A. Blood pressure is over 140/90
B. Albumin or sugar is present
C. There are any finding or history of urinary disease
D. Applicant is a diabetic or high blood pressure

7. A. Are you aware of any unfavourable features which affect his / her longevity
   (i) form the personal or family history? ☐ No ☐ Yes.....
   (ii) disclosed by your medical examination? ☐ No ☐ Yes.....
   B. Do you recommend any additional tests or reports? ☐ No ☐ Yes.....

I hereby cartify that I have made this examination in private at.....

..... on this.....day of.....at.....AM/PM

Insured or Payer Signature
(To sign in front of Doctor)

.....M.D.
Medical Examiner

DOCTOR - PLEASE CHECK YOUR REPORT FOR ANY OMISSION

(To be used only in case of children under age of 16 years)

PART 2 EXAMINATION OF CHILD (Strip child to waist)

Full name of child examined ☐ Male ☐ Female	Date of birth	Height (cms.)	Age
	Agent's name and code	Weight (kgs.)	Race

If the answer is "Yes", Please identify more of details

1. A. Has the child any impairment of physical growth or mental development or peculiar look?
   ☐ No ☐ Yes Please identify.....
   B. Has the child any impairment of sight or hearing? ☐ No ☐ Yes.....
   C. Has the child any deformity or lameness? ☐ No ☐ Yes.....
   D. Has the child been hospitalized? ☐ No ☐ Yes When? Where? Why?.....
   .....

2. After careful inquiry and examination, do you find any evidence of past or present illness of :
   A. Brain or nervous system? Convulsion? ☐ No ☐ Yes.....
   B. Heart or lungs? ☐ No ☐ Yes.....
   C. Abdomen, Kidneys or urinary tract? ☐ No ☐ Yes.....
   D. Bones, joints or muscles? ☐ No ☐ Yes.....
   E. Eyes, ears, nose, throat, skin, glands or other parts of the body? ☐ No ☐ Yes.....
   F. Endocrine or other diseases? ☐ No ☐ Yes.....

3. Are you satisfied as to Child's identity?.....

4. Is the child normal and healthy in your opinion? (Any weight change in the past 6 months?)
   .....

5. Urinalysis (Age over 5 years) Albumin.....Sugar.....

ข้าพเจ้าขอรับรองว่าเป็นผู้ปกครอง และได้นำผู้เยาว์นี้มารับการตรวจจากแพทย์จริง

ลงชื่อ.....ผู้ปกครอง

( )

Additional remarks : (State anything discovered by you, not fully set forth above, which may influence the risk).....

.....

.....

I certify that I have carefully made this examination at.....

(Address)

On date (dd/mm/yyyy).....Time (HH.MM).....AM/PM

.....M.D.

Medical Examiner

DOCTOR - PLEASE CHECK YOUR REPORT FOR ANY OMISSION