DELTA LIFE INSURANCE COMPANY LIMITED

Delta Life Tower, Plot - 37, Road - 90, Gulshan Circle - 2, Dhaka - 1212, Bangladesh

PERSONAL STATEMENT AND MEDICAL REPORT

1. (a) Name in Full .....
   (b) Father's Name ..... Husband's Name
   (c) Occupation .....
   (d) Residential Address .....
   .....

2. (a) Age at Nearest Birthday .....
   (b) Single/Married/Widower
   (c) Sum Assured Tk .....
   (d) Plan ..... Term .....

3. What is the present state of your health? .....
4. What is your category or classification of Health (Service record)? .....

STATE YES or NO.

5. Is there any hereditary disease in you and your family, such as Insanity, Epilepsy, Rheumatism, Diabetes, Asthma, Blood dyscrasia Tuberculosis, Cancer or Leprosy, either on the paternal or maternal side?

6. Have you ever suffered, if so, how often, when and for how long?

a) Epilepsy, Giddiness, Fits, congenital, Mental/ Nervous Disorders, Frequent Headaches.

b) Persistent cough, Bloodspiting, Chronic Bronchitis, Pneumonia, Pleurisy, Tuberculosis or disorders of respiratory system.

c) Appendicitis, Ulcer (Gastric or Duodenal) or any orher disorder of gastrointestinal tract, liver or spleen.

d) Hernia, Piles, Fistula, Disorders of Bones, Joints or Spine.

e) Faintness, Palpitation, Dropsy or any Disease of Heart or Blood Vessel, or of High or Low Blood pressure.

★ Give details if any of the above question is answered "Yes"

f) Renal Colic or Renal Stone, Disorders of Kidney, Bladder, Urinary Tract, genital Organs (Internal and External) Syphilis, Gonorrhoea, Diabetes, Presence of Sugar or Albumin or Pus in urine.

g) Any Surgical Operation, Accident or Injuries to joints, bones or soft tissues of the Blood.

h) Goitre, Tumours (whether benign or malignant) Cancer, Diseases of Glands, Skin or of Blood.

i) Any disease not mentioned above.

7 (a) Have you ever had an electrocardiogram or an X-ray taken of any part of the body? If so, when and for what complaint? What were the findings?

b) Have you consulted or been treated by any medical practioner for any illness? If so, for what & when? Give name & address of the Doctor.

c) Are you addicted to any Drug, Tobacco, Alcohol etc.?

8. Family Record:

		IF LIVING		IF DEAD		
	No.	Age	State of health	Age at death	Cause of death	Year of death
Father						
Mother						
Brother(s)						
Sister(s)						
Spouse						
Son(s)						
Daughter(s)						

9. FOR FEMALE ONLY:

a) Are you pregnant at present? If so, When do you expect Childbirth?

b) How many Children you have?

c) Were there any difficulty (ies) or abnormality (ies) during childbirth? If so, give details .....
.....

d) Have you ever suffered from any diseases of the breast or the uterus?
.....
.....

Place: ..... Date .....

Sd/-
Signature of Medical Examiner

Sd/-
Signature of the Policy Holder/L. T. I.

CONFIDENTIAL REPORT OF THE MEDICAL EXAMINER

Name of Proposer ..... Introduced by .....

STATE YES or NO

1. (a) Are you in any way related to the applicant?	
(b) Is the age by appearance, in your opinion, the same as stated in the proposal?	
(c) Does the applicant show any signs of premature ageing?	
2. (a) Is the complexion anaemic, puffy or otherwise unhealthy? If so, describe.	
(b) Are there any defects, deformities or abnormalities in eyesight or hearing? If so, describe.	
(c) Are there any enlarged glands, tumours, or any evidence of skin disease?If so, describe.	
3. (a) Is there any disorder of gastro-intestinal tract?	
(b) Is the liver or spleen enlarged? If so describe.	
(c) Are gums & teeth healthy?	
4. (a) Does the chest expand easily and equally in all directions? Is it uniformly shaped?	
(b) Are the sounds of the heart normal? If so, describe.	
(c) Do you consider lungs healthy by auscultation and percussion? If otherwise, describe abnormality?	
5. (a) State the frequency and character of the pulse.	
(b) Is there any indication of sclerosis?	
(c) Blood pressure: Systolic/Diastolic	
(d) Are the sounds of the heart normal? If not, what abnormality is present?	
(e) Does the proposer suffer from precordial pain, breathlessness on slight exertion, oedema of ankles or any other symptom of cardiac insufficiency? (In case of doubt, the proposer should be put through an exercise test).	

6. Is there anything to suggest syphilis, gonorrhoea, stricture urethra, disease of the prostate gland or of the testicles, kidney or urinary tract?	
7. Kindly state the reasons which guided you in classifying the life, and add remarks on any point you may deem material whether covered by tye questions or not.	

URINE EXAMINATION RESULT:

8. (a) Sp.gr ..... Suar ..... Albumin .....

(b) Was Urine found free from abnormalities? ☐

(c) Was the Urine passed in your clinic? ☐

9. (a) Height ..... cm./ft-inch.

(b) Weight ..... kg/Lbs.

(c) Chest (Insp) ..... cm /ft-inch.

Chest (Exp) ..... cm./ft-inch.

(d) Abdomen ..... cm./ft-inch.

10. From the physical examination and family history of the applicant has he/she a fair chance of longevity and do you consider him/her to be a first class life? ☐

Details, if any?

Place ..... Date .....

Name in Block Letters .....

Signature of Doctor .....

Degree .....

Date of Degree ..... Reg No .....

University ..... Code No .....

Present Address .....

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