

Proposal No.										
Name of FA/BM/AGM/DGM (Who Introduce):										
Code No:										



Akij Takaful Life Insurance PLC
Paltan China Town (15th Floor),
East Tower, 67/1, Naya Paltan,
VIP Road, Dhaka-1000.

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

INSTRUCTIONS TO THE MEDICAL EXAMINER:

1. When an examination is begun the report there of becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid a declination.
2. An Examiner must confirm the Proposed Insured in presence physically.
3. An Examiner is not permitted to examine his relatives or applicants of a Financial Associate who is a relative.
4. Any erasures or alterations in your report must be initialed by you.
5. Tick (✓) the appropriate box and brief details where needed
6. Medical Examiner's report must be recorded in your handwriting.

Full Name of Proposed Insured: _____

Date of Birth/Age: _____ **Sex :** Female Male

Occupation: _____

SL. No	QUESTIONNAIRE	YES	NO	COMMENTS															
1	Have you ever seen the proposer professionally before? If YES, when and why? If NOT, do you know the proposer for other reasons?																		
2	Is the Proposer Currently Under any Medical Treatment/Sufferings from any Diseases/Any Medication? (If 'YES' State in Comments Column: Since When and for Which Condition? Also write his/her Medication/Treatment)																		
3.	GENERAL APPEARANCES	YES	NO	COMMENTS															
a	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Height (In Shoes)</td> <td style="width: 20%;">Weight (Clothed)</td> <td style="width: 20%;">Chest (Full Inspiration)</td> <td style="width: 20%;">Chest (Forced Expiration)</td> <td style="width: 20%;">Abdomen at Umbilicus</td> </tr> <tr> <td>..... ft.....inch</td> <td>..... lbs.</td> <td>..... inch</td> <td>..... inch</td> <td>..... inch</td> </tr> <tr> <td>OR cm</td> <td>OR kg</td> <td>OR cm</td> <td>OR cm</td> <td>OR cm</td> </tr> </table>	Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen at Umbilicus ft.....inch lbs. inch inch inch	OR cm	OR kg	OR cm	OR cm	OR cm			
Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen at Umbilicus															
..... ft.....inch lbs. inch inch inch															
OR cm	OR kg	OR cm	OR cm	OR cm															
b	Healthy, looks declared age?																		
c	Morphological type?																		
d	Are there any malformations or mutilations?																		
4	NECK	YES	NO	COMMENTS															
	Is there Evidence of Goiter?																		

	For Men:												
b	Are There Any Signs of Disease of The Genital Organs, (Testes, Epididymis, Prostate)?												
c	Is there Gynecomastia?												
	For Women:												
d	Are There Any Signs of Disease of The Genital Organs?												
e	Are There Any Abnormalities of The Breasts?												
f	Is She Pregnant?			If 'Yes' How for advanced?									
9	CENTRAL NERVOUS SYSTEM	YES	NO	COMMENTS									
a	Previous History?												
b	Sequelae												
c	Are the Papillary, Abdominal or Tendon Reflexes Abnormal?												
d	Are There Any Signs of Autonomic Nervous Dysfunction?												
e	Are There Any Psychiatric or Neurological Abnormalities?												
10	SKIN AND TEGUMENTS	YES	NO	COMMENTS									
	Are there any signs of:												
a	Jaundice or Cyanosis?												
b	Skin Eruption, Cyst, Tumor, Varicosities or Edema?												
c	Lymphadenopathy?												
d	Scars or Tattoos?												
e	Tophi or Xanthomata?												
11	SKELETAL SYSTEM	YES	NO	COMMENTS									
	Are there any abnormalities of the bones, joints or intervertebral discs?												
12	SENSORY ORGANS	YES	NO	COMMENTS									
a	Is there any Disease of the Eyes?												
b	Visual Acuity:	<table border="1"> <thead> <tr> <th></th> <th>R</th> <th>L</th> </tr> </thead> <tbody> <tr> <td>Before Correction</td> <td>/10</td> <td>/10</td> </tr> <tr> <td>After Correction</td> <td>/10</td> <td>/10</td> </tr> </tbody> </table>				R	L	Before Correction	/10	/10	After Correction	/10	/10
	R	L											
Before Correction	/10	/10											
After Correction	/10	/10											
c	Is there any Disease of the Ears?												
13	OTHERS	YES	NO	COMMENTS									
a	Are There Any Stigmata of Alcohol, Tobacco, or Drug Abuse?												
b	Family History: Have any Members of Proposed Insured Family (Parents/Siblings) suffered from: Tuberculosis, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease, Mental Illness or Suicide?			Which Disease?									

c	Are There Any Repercussions of The Proposer's Professional or Social Activities on The General State of Health?						
14	CONCLUSIONS:	YES	NO	COMMENTS			
a	Do You Know or Suspect Anything Adverse About Proposed Insured's Health, Character, Mentality, Habits or Morals Not Other Wise Covered Above?						
b	Are There Any Risks of Invalidity or Partial or Total Disability?						
c	The Proposer's State of Health Is Considered to Be:	<input type="checkbox"/>	GOOD	<input type="checkbox"/>	AVERAGE	<input type="checkbox"/>	POOR

SPECIAL COMMENTS OR SUGGESTIONS OF THE EXAMINING PHYSICIAN

I confirm that I have asked the questions stated on the face of this report form and have recorded in full the answers given to me by the proposed Insured. I further confirm that I have made this examination in private at (place)

.....Date 20.....
atam/pm.

Signature of Physician: _____

Name of Physician: _____

BMDC Reg. No: _____

Stamp/Seal : _____

Signature of the Proposed Insured

MER CREDIT VOUCHER

Proposal No: _____ Medical Examination Date: _____

Full Name of Proposed Insured: _____

Name of FA/BM/AGM/DGM (Who Introduced): _____

FA/UM/BM/AM Code No.: _____

Name of Physician: _____ ME Code: _____

Stamp/Seal: