Long Form Health Certificate Application

and Health Certificate in Connection with Application for (Not to be used for Juvenile Policies)

LIBERTY

ADVISE INSURE INVEST

Regulated by the Insurance Regulatory Authority

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Policy Number | Agency Code Number

☐ Reinstatement ☐ Removal or Reduction Rating Change in ☐ Plan ☐ Amount

Addition of ☐ ADB ☐ WP ☐ AI (AX) Addition of ☐ MIB _____ per Month for _____ years

PERSONAL DETAILS

1. Name in full

Surname

I.D. Card Number | Telephone number

Place of birth | Date of birth D D M M Y Y Y Y

Citizen of (country)

Current address (if different from above):

Mobile Phone. | Home Phone

Employers name (if applicable) | Occupation

Telephone (office) | Fax number

E-mail address

Date joined company D D M M Y Y Y Y | Date became contributor D D M M Y Y Y Y

2. A What is your present occupation? (All if more than one)

B What are your daily duties?

C What is your employer's name and address?

3. Have you now or do you expect or have any connection with

A Military or naval service? ☐ Yes ☐ No

B Aerial navigation or piloting? ☐ Yes ☐ No

4. A - Are you or do you contemplate negotiating for other life insurance? ☐ Yes ☐ No

B - Since date of your application for the above-numbered policy, have you applied, either formally, or informally for new insurance, change of plan or reinstatement, which was declined, postponed, withdrawn or modified in kind, amount or rate? ☐ Yes ☐ No

If yes, state to what companies, date and cause.)

5. A Since that date, have any deaths occurred in your family, parents, brothers and sisters, husband or wife? ☐ Yes ☐ No
B- If so, state relationship, age and cause of death.

6. **AIDS (Acquired Immune Deficiency Syndrome) Questions 6**

A Have you received medical advice or treatment in connection with AIDS or an AIDS-related condition or a sexually transmitted disease? ☐ Yes ☐ No

B- Have you been told you had AIDS or an AIDS-related complex? ☐ Yes ☐ No

C- Have you had or been told you had a positive blood test for antibodies to the AIDS virus (Human Immune Deficiency virus)? ☐ Yes ☐ No

D- Do you have any of the following which are unexplained : fatigue, Weight Loss Diarrhoea, enlarged Lymph nodes or unusual skin lesions? ☐ Yes ☐ No
(If yes to any questions give full details)

7. Since date of your application for the above-numbered policy

A - Have you been ill or injured? (Give all dates and details) ☐ Yes ☐ No

B - Have you consulted or been treated by anyone on account of your health or your physical or mental condition? (Give all dates and details) ☐ Yes ☐ No

(Give all dates and details)

C Have you been a patient in any hospital or sanitarium? ☐ Yes ☐ No

(Give all dates and details)

8. A - What is your present weight (in usual clothing without overcoat)?

B - Present height (in shoes)? _____ ft _____ .in

9. Are you now in good health? ☐ Yes ☐ No

10. What insurance is now in-force on your life? (including accident policies and business insurance if any)

Name of Company	Amount	Year of Issue	Family Income or Similar Benefit	Waiver of Premium Benefit	Disability income Benefit	Accidental Death Benefit

I HEREBY DECLARE, on behalf of myself and of any person who shall have or claim any interest in said Policy that each of the above answers is full, complete and true, and agree that they shall be taken as the exclusive basis of the reinstatement, change or issue of the insurance to which this application relates, and that such reinstatement, change or issue shall not be considered as effected by reason of any cash paid or settlement made in payment of or on account of the amount now due until this application shall be duly approved at the Head Office of the Company, or that the receipt, retention, deposit or cashing of any such payment or settlement by the Company or its agent shall not constitute a waiver, forfeiture, or otherwise affect this condition. Notwithstanding any provision to the contrary in the said policy I further agree that the policy, if reinstated or modified in such manner as to increase the risk, shall become contestable but shall be incontestable after it has been in force during the lifetime of the insured for two years from the date of this application, except for no payment of premium.

I have paid_____on account of charge for reinstatement, change or issue of insurance under Policy number_____ in accordance with the provisions of the Conditional Receipt bearing the number of this Application dated at_____ this_____day of_____

_____ _____

(Signature of Witness) (Signature of Insured)

MEDICAL EXAMINATION

1. How long have you known the Proposed Insured? ____________________

   Are you related? ☐ Y ☐ N Race ____________________

2. A Height ☐ ☐ feet ☐☐ inches

   Did you

   Weigh him? ☐ Y ☐ N

   Measure him? ☐ Y ☐ N

   Girth

   Chest forced expiration ☐☐☐ inches

   Chest full inspiration ☐☐☐ inches

   Abdomen at umbilicus ☐☐☐ inches

3. Does inquiry or examination reveal any past or present disease of brain, chest, digestive, genito-urinary, cardiovascular, renal, glandular or

   A) Is his appearance unhealthy? ☐ Y ☐ N

   B) Does he appear older than age given? ☐ Y ☐ N

   If yes please explain

   ____

   ____

   C) Is there any impairment of sight or hearing? ☐ Y ☐ N

   D) Are pupillary and patellar reflexes abnormal? ☐ Y ☐ N

   E) Is there any deformity or other physical defect? ☐ Y ☐ N

   F) Has serological test for syphillis ever been made? ☐ Y ☐ N

   Give reason, date, result)

   ____

   ____

   G) Are there any abdominal, varicosities or hernias? ☐ Y ☐ N

   Locate, describe in detail)

   ____

   ____

   ____

   H) Do you know anything about his character, habits or morals which would affect the risk adversely?

   ____

   ____

   ____

   I) Is there any evidence or arteriosclerosis or aneurysm? ☐ Y ☐ N

   J) Is there:

   a heart murmur? ☐ Y ☐ N

   any hypertrophy? ☐ Y ☐ N

CONDITIONAL RECEIPT

Received of________________________________ the sum of________________________________

On account of charge for reinstatement, change or issue of insurance under Policy No________________________________ issued by the Liberty Life Assurance Ltd. upon the life of________________________________

Reinstatement change or issue shall not take effect until application therefore, dated the____________________day of.________________________________shall be duly approved at the Head Office. The receipt, deposit or cashing or other use by the Company or its agent of said sum shall not in any manner effect this condition. If the Company declines such application, the consideration received will be returned on surrender of this receipt.

____

Agent or Cashier

4. Blood Pressure (if over 140 systolic or 90 diastolic, record 3 readings)			
Systolic			
Diastolic (Disappearance of sound 5th phase)			

	AT REST	AFTER EXERCISE	3 MINUTES LATER
5. Pulse Rate			
Irregularities per minute			

6. Urinalysis	Specific Gravity	Albumin	Sugar

In addition to your analysis of the urine, send a portion to a qualified laboratory if

a. Requested by local office
b. Applicant is over 60 years old
c. Blood pressure is over 140 Systolic or 90 Diastolic.
d. Any urinary abnormality found or suspected.
e. There is any history of albumin or sugar, including family history of Diabetes.
f. There are any findings or history of kidney, prostrate, bladder or genito-urinary disease

Examinations made

At Applicant's place of business ☐ Time H H - M M

At Applicant's Residence ☐ Time H H - M M

At Examiner's office ☐ Time H H - M M

On_____Day of _____20_____

7. Name of his medical attendant

Address

Details

8. (a) Are there any signs, symptoms or history which may relate to AIDS or an AIDS-related complex ? ☐ Y ☐ N

(b) Do you know or suspect anything adverse about the proposed Insured's health, character, mentality habits or morals not otherwise covered above? ☐ Y ☐ N

(A confidential report may be sent to the Medical Director)

PLEASE PRINT Name of Medical Examiner

Address of Medical Examiner

Signature of Medical Examiner _____ Date D D - M M - C C Y Y

NOTICE

This is a temporary receipt only if the reinstatement or change requested is approved, a regular receipt by an executive officer of the Company and countersigned the Agency Cashier will be given to you.

If you do not hear from the Company in relation to the insurance within sixty days, notify the Company at its Head Office.