

To avoid delays in processing this document please complete all sections carefully in English using block capitals and ensure all tests are completed.

TO THE APPLICANT

Sections A, B, C and D of this report are to be completed prior to the medical examination. Please read also the questions on the following pages so that you can answer them at the medical examination. The information given will constitute the basis for the application for insurance. Incorrect or incomplete information from the applicant can invalidate the insurance.

MEDICAL EXPENSES

Nordben Life and Pension Insurance will reimburse you with all reasonable medical costs incurred in the application to the Company for a policy with risk benefits, provided valid receipts are forwarded. Please therefore settle the medical account direct with the doctor and then forward a copy of the invoice, together with the receipt to the address printed on the last page of this report.

PLEASE NOTE: If the proposal is accepted by Nordben reimbursement of the medical costs will be made on receipt of the first premium payment. If however Nordben should decline the proposal reimbursement will be made immediately. Reimbursement will be made in the currency of the proposed premium irrespective of the currency of the medical costs. The maximum amount reimbursed will be at a level consistent with the average costs of medicals and tests in European countries.

TO THE MEDICAL EXAMINER AND THE APPLICANT

All questions in Section H are to be answered correctly and with care. The fee for the examination is to be paid by the applicant at the examination.

TO THE MEDICAL EXAMINER

Please see overleaf any additional tests that may be required at this examination. The medical examiner should read the applicant's answers in Sections A, B, C, D, E & F prior to completing Section H. Nordben Life and Pension Insurance Co. Limited asks you not to disclose any of your findings or anticipate the appraisal of the case from the insurance point of view by commenting on the significance of any observation to the applicant. The medical examiner and the applicant should not be near relatives or have any other special relationship with each other.

HOW WILL THIS DOCUMENT BE USED?

Nordben Life and Pension Insurance Co. Limited will use this Medical Report and other details (for example, reports from a Doctor, your occupation, residence) to decide whether and on what terms to offer insurance. For these purposes this Medical Report will be disclosed to relevant Nordben staff and to the Company's Consultant Medical Officer and to co-insurers, third party life reinsurers and their retrocessionnaires. It might also be necessary to obtain additional details from the doctors and insurance companies, referred to in this Report, for the purpose of reaching our insurance decision.

The insurance decision will only be disclosed to you and/or your employer depending on the contract of insurance. We will never disclose medical reports, additional reports from insurance companies etc to you or your employer without their written approval.

The insurance decision will take the form of you being accepted on ordinary premium rates, on an increase to our ordinary premium rates or us applying special exclusions to your insurance. This decision will be disclosed to you and/or your employer, depending on the contract of insurance.

By signing the 'Declaration' you will have given consent to our disclosing appropriate details from this document to them. No sensitive data is passed on to a third party unless the correct legal procedure is followed. The Medical Report will be held on file as it forms part of the insurance contract and will be disposed of in accordance with the terms of the contract.

The Medical Report will be reviewed should you make a claim under the insurance to ensure that you have not withheld information that would have been relevant to our insurance decision.

Nordben Life and Pension Insurance Co. Limited takes the privacy and security of data held on its clients very seriously. We have published a guide to ensure that our clients are informed about their rights and our obligations under The Data Protection (Bailiwick of Guernsey) Law. The guide is on our website www.nordben.com/data-protection.

In addition to the Medical Examinations, can you please carry out the following tests where indicated.

TEST	INSTRUCTIONS	YES	NO
HIV AIDS TEST	Please carry out ELISA HIV antibody test for the presence of HIV1 AND HIV 2. The results of this test must be submitted to Nordben attached to this report.		
BLOOD TEST	See below for details.		
ELECTROCARDIOGRAM (ECG)	Please conduct an ECG examination at rest using at least 3 standard and 3 chest leads. Please also conduct a symptom limited exercise stress test providing a detailed report to include the type and amount of exercise performed with pulse rates and blood pressures recorded at intervals during the test and post-recovery phase which should continue for at least 6 minutes. For those with a lesser exercise capacity or in an older age group the medical examiner should be present at all times.		
MICROSCOPIC URINALYSIS			
PULMONARY FUNCTION			
HEPATITIS PROFILE	To include: Anti HAV, Anti HBs (HBsAb), HBsAg *, Anti HCV Where HBsAg is positive we will require HbeAg.		

BLOOD TEST DETAILS TO BE COMPLETED

1.	Blood sedimentation rate	_____	mm/Westergren				
2.	Blood picture:	Erythrocytes	_____	Mio/ul	Haemoglobin	_____	g%
		Haematocrit	_____	Vol.%	MCV (Mean corpuscular volume)		
		Leukocytes	_____	/ul	Thrombocytes	_____	ul
3.	Blood chemistry:	Result		Normal value			
	Fasting Blood Sugar	_____	mg%	_____	_____	_____	mg%
	Creatinine	_____	mg%	_____	_____	_____	mg%
	Urea	_____	mg%	_____	_____	_____	mg%
	Total Cholesterol	_____	mg%	_____	_____	_____	mg%
	HDL-Cholesterol	_____	mg%	_____	_____	_____	mg%
	LDL-Cholesterol	_____	mg%	_____	_____	_____	mg%
	Triglycerides	_____	mg%	_____	_____	_____	mg%
	Uric acid	_____	mg%	_____	_____	_____	mg%
	Bilirubin	_____	mg%	_____	_____	_____	mg%
	Serum Alkaline Phosphate (SAP)	_____	mg%	_____	_____	_____	mg%
	Gamma-GT	_____	U/l	_____	_____	_____	U/l
	GOT	_____	U/l	_____	_____	_____	U/l
	GPT	_____	U/l	_____	_____	_____	U/l
What is your fee?		_____		(To be paid by the applicant following the examination)			

Questions to be answered by the applicant prior to medical examination.
Please write clearly and in English using block capitals.

A. GENERAL DETAILS

Full name:	_____	Date of birth: (dd/mm/yyyy)	_____
Address:	_____		
	Telephone no:	_____	
	Facsimile no:	_____	
	E-mail:	_____	

Post code:	_____		
1.	Birth place:	_____	
2.	Nationality:	_____	
3.	Occupation:	_____	
4.	If you are applying to join an employer/company sponsored pension plan, please state the name and address of the employer/company:		
	Employer's name:	_____	
	Address:	_____	
	Telephone no:	_____	
	Facsimile no:	_____	
	E-mail:	_____	

	Post code:	_____	
5.	If you have a doctor you usually consult, please give details:		
	Doctor's name:	_____	
	Address:	_____	
	Telephone no:	_____	
	Facsimile no:	_____	
	E-mail:	_____	

	Post code:	_____	

A. GENERAL DETAILS (Continued)

Please place a tick in either of the Yes/No boxes

If "Yes", please give full details:

6. Have any of your parents, brothers or sisters died or had any serious or hereditary disorder (e.g. heart disease, high blood pressure, stroke diabetes, cancer) before 60 years of age?

Yes No

7. Have you been off work due to illness or accident for more than 5 continuous working days in the last 12 months? Please indicate when, how long and why:

Yes No

Name and address of doctor consulted:

Doctor's name: _____

Address:

_____ Telephone no: _____

_____ Facsimile no: _____

_____ E-mail: _____

Post code: _____

8. Are you taking any medication, receiving treatment or following a special diet, or have you done so within the past 12 months? If "Yes", why and what medicine, dosage and treatment?

Yes No

Prescribing doctor: _____

Address:

_____ Telephone no: _____

_____ Facsimile no: _____

_____ E-mail: _____

Post code: _____

9. Has any proposal for insurance on your life been declined, postponed, accepted at an extra premium or on special conditions?

Yes No

Name of company: _____

Address:

_____ Telephone no: _____

_____ Facsimile no: _____

_____ E-mail: _____

Post code: _____

A. GENERAL DETAILS (Continued)

10.	Do you take part in, or have you any intention of taking part in, any hazardous activities or sports? If so, which and how often?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
11.	Do you already hold, or are you planning to take out, cover of a similar nature to that to be provided by this insurance policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If "Yes", please provide full details of the amount and type of cover and state whether it is to remain in force:		
	Cover:	_____	
	Policy date:	_____	
	Insurance company:	_____	

B. OCCUPATION DETAILS

1.	Job title:	_____		
2.	How many hours do you normally work each week?	_____		
3.	Do you undertake purely administrative work?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If "No", please provide full details (e.g. of any driving, manual labour, height work, diving, using explosives etc.)			

4.	In which countries will you be working?	_____		
5.	Days of business travel per annum?	_____		
6.	Mode and frequency of business travel? (Number of flights, boat trips)	Mode: _____	Frequency: _____	_____
		_____	_____	_____
		_____	_____	_____

C. RESIDENCE DETAILS

1.	In which countries will you be living?	_____
2.	Estimated length of stay?	_____
3.	Please describe the areas where you will mainly stay (e.g. big cities, rural or remote areas):	_____
4.	Where are the nearest medical facilities?	_____
5.	What type of medical facility is it? (e.g. doctor, clinic, hospital etc.)	_____
6.	How would you assess the overall medical care and sanitary conditions where you will stay?	_____

D. EMPLOYER MEDICAL DETAILS

1	When did you last undergo an Employer Medical examination?	Date: (dd/mm/yyyy) _____
2.	Has the doctor at an Employer Medical examination (in the last 3 years) ever raised any medical concerns, given you specific advice etc.?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If "Yes", please give full details: _____ _____	
3.	How often do you attend Employer Medicals? _____	

E. MEDICAL DETAILS

Questions to be answered by the applicant in the presence of the medical examiner (please observe instructions on front page). If any question is answered "Yes", please give details regarding type of disease, onset, duration and course of the disease, treatment, relapses – if any, and date on which you were free some symptoms. Remaining symptoms and findings should be given. Which doctor was consulted? In case of hospital care, please give name of department (medical, surgical, etc.)

An illness, physical or nervous, - major accidents and physical handicaps, are to be included.

Where necessary, please use the additional information box or a separate sheet when answering the following questions. Thank you.

1.

Have you ever had, or are you currently suffering from:

If "Yes", please supply, where relevant, full details including dates, treatment given and time off work. Use box in Section F for additional information:

(a) Heart disease, tightness or pains in the chest, angina, swollen legs, palpitation of the heart, irregular pulse or breathlessness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(b) High blood pressure (blood pressure readings)? Stroke? Hardening of the arteries or any other disease of the heart or any circulation problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(c) Asthma, bronchitis or any infection of the lungs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(d) Recurring indigestion, disease of the liver or pancreas, ulcer, colitis or other bowel problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(e) Infection or disease of the kidneys or urinary tract? Symptoms of the prostate?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(f) Albumen or sugar in the urine? Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(g) Rheumatism, arthritis or other disease or impairment affecting the joints or muscles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(h) Sciatica, prolapsed disc, discomfort or pains in the back, neck or arms?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(i) Tumours? Disease of the lymph glands? Disease of the blood?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

E. MEDICAL DETAILS (Continued)

(j)	Epilepsy, convulsions, paralysis or any other disease of the nervous system? Vertigo? Fainting attacks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(k)	Stress, depression/anxiety state, insomnia, mental illness or any psychiatric disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(l)	Alcohol problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(m)	Disease of the eyes? Disease of the ears? Poor sight or hearing? If wearing glasses state the strength of the lenses.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(n)	Disease of the skin, eczema or other allergic disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(o)	Thyroid disease, hormonal disorder, or disturbance of the metabolism?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(p)	Disease of the genital organs, or for females only, any gynaecological illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
(q)	Any other serious or chronic disease? Any physical handicap or abnormality? Any psychological problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2.	Do you use or have you ever used any stimulant or sedative drugs (including narcotics)? If yes, which stimulants, sedative drugs, during which time and when was the last time? Name and address of attending doctor, if any?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3.	Have you ever been tested positive for HIV/AIDS or Hepatitis B, C or have you been tested or treated for other sexually transmitted diseases, or are you awaiting the result of such a test? If you have, then specify when and where, name and address of doctor and results.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4.	Have you ever received treatment or been examined by any other medical institution or by any other doctor or other medical personnel than stated above? If yes, for what reason and when? Please give name and address details and in case of hospital treatment, please indicate at which department and whether as an in or out-patient.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5.	Do you smoke? If "Yes", state average DAILY quantity. If "No", for how long have you been a non-smoker?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6.	Do you drink alcohol? If "Yes", state average WEEKLY alcohol intake.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7.	Are you at present pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8.	What is your height and weight?		Height: m cms Weight: kg

F. ADDITIONAL INFORMATION

G. DECLARATION

<p>Important note</p> <p>Material facts are facts which Nordben Life and Pension Insurance Co. Limited would regard as likely to influence the decision whether or not to accept the application for insurance. Failure to disclose any material fact may result in the insurance being ineffective, even if the application for insurance was accepted by Nordben Life and Pension Insurance Co. Limited. You should disclose any fact if you are unsure whether or not it is material to the proposed insurance.</p> <p>I declare to the best of my knowledge and belief that the statements in sections A, B, C, D, E & F are true and complete and that I have not withheld any material facts (see important note above). I consent to Nordben Life and Pension Insurance Co. Limited seeking medical information from any doctor who has attended me concerning anything which affects my physical or mental health and seeking information from any insurance office to which an application has been made for insurance on my life and I authorise the giving of such information. I confirm that I have checked and found correct any statements in this document that are not in my own handwriting.</p> <p>Place: _____ Date: (dd/mm/yyyy) _____</p> <p>Name: _____</p> <p>Signature: _____</p>

H. MEDICAL EXAMINATION

Questions to be answered by the medical examiner

1.	How have you convinced yourself of the identity of the applicant?	_____
2.	Is the applicant known to you? If "Yes", since when?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
	Have you previously treated the applicant? If "Yes", please summarise.	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
	_____	_____
3.	The applicant's general condition. Physical abnormality, physical or mental handicap? If so, please give a detailed description. In case of scoliosis, please quantify by giving degree of curve if available.	_____
	_____	_____
	_____	_____
4.	Height, without shoes, cm	_____
	Weight, with minimal clothing, kg	_____

H. MEDICAL EXAMINATION (Continued)

9.	Urinalysis		_____
	(a) Albumen? If orthostatic albuminuria is suspected, please also examine morning urine). If positive, test with stix (e.g. Albustic); a Heller test, sulphosalicylic acid test or equivalent tests should be conducted.		_____
	(b) Sugar?		_____
	(c) Blood?		_____
	(d) Pathological sediment or equivalent examination? (Always to be examined if a disease of the kidney or urinary tract is suspected or has occurred during the past two years or if the diastolic blood pressure exceeds 100 mHg.)		_____
	N.B. If protein or glucose is present, please ask the proposer to deliver a further specimen for testing, passed immediately on rising or one or two hours post prandially.		
10.	Is there enlargement of the liver or the spleen or other signs of abdominal disease? Hernia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
11.	Are there any reasons for suspecting a disease of the mammary glands or of the genital organs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
12.	Notable disturbances of vision or hearing? If so, to what degree? In the event of myopia of .6 diopters or more in either eye, state the number of dioptres.		_____
	Are there signs of progressive eye disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
13.	Are there any signs of disease affecting other sensory organs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
14.	Does the skin show pathological changes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
15.	Are there any enlarged lymph glands?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
16.	Is there any evidence of disease of the back, bones or joints? If symptoms from the joints have occurred during the last two years, please give ESR.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
17.	Are there any reasons for suspecting:		_____
	(a) Disease of the nervous system?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
	(b) Mental disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
	(c) Current or previous abuse of alcohol, hypnotics, narcotics etc.?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
18.	Are there any circumstances or symptoms that can be associated with a HIV-infection, AIDS related condition or AIDS? (Please consider factors like behaviour, previous hepatitis B, syphilis or other sexually transmitted disease, amoebic dysentery, recurrent infections of unclear origin, diarrhoea of long duration, severe weight loss, night sweats, long lasting fever of unknown origin, lymphadenopathy, fungal infections, skin and nail lesions.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
19.	Do you know anything else about the applicant that might influence the appraisal of this application?		_____

H. MEDICAL EXAMINATION (Continued)

20.	Describe any vulnerability of applicant to a particular disease or premature death or disability. (Please summarise)	_____

21.	General appraisal of state of health of the applicant (summary). If you consider further examinations desirable, please recommend these.	_____

22.	Do you consider the applicant in perfect health at present?	Yes <input type="checkbox"/> No <input type="checkbox"/> _____

I. DECLARATION

I hereby declare that the applicant has, in my presence, answered the questions in sections E & F of this form and has signed his name there-under with his own hand, and that I myself have answered the questions addressed to me in section H as accurately and truthfully as possible.

Place: _____ Date: (dd/mm/yyyy) _____

Name of doctor: _____ Registered Health Authority: _____

Signature: _____

Address: _____

_____ Telephone no: _____

_____ Facsimile no: _____

_____ E-mail: _____

Post code: _____

Qualifications: _____

Obtained at: (Name of Medical School, University etc.) _____

This report is to be sent by the examining doctor to:

The Consultant Medical Officer
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