

SABB Takaful سبب تكافل

HSBC  عضو مجموعة

MEDICAL EXAMINER'S CONFIDENTIAL REPORT

It is requested that the medical examiner satisfies him/herself as to the identity of the proposed. As the report is a strictly confidential statement, the examiner is requested to forward it to SABB Takaful Company and not to communicate its contents to the proposed or to any agent of the Company.

DETAILS OF PARTICIPANT

Name of Proposed Participant		Name of Employer	
Occupation	Saudi ID/Iqama No.	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Important Note: Participant is required to disclose in this report fully and faithfully, all the facts which he/she knows or ought to know, otherwise the Takaful Plan issued hereunder would be void.

ملاحظة هامة: المشترك مطالب بالإفصاح الكامل في هذا التقرير عن كل الحقائق التي يعرفها أو التي يجب أن يعرفها، وإلا سوف يعتبر برنامج التكافل المصدر باطلاً.

Declaration: Having made an application for a Family Takaful Benefit on my life with SABB Takaful Company, in accordance with the proposal and upon the terms to be contained in such Takaful Plan as shall be granted in pursuance thereof, I declare that the answers to the questions below are true, and that I have not withheld any information. I understand that such answers and the answers given to the separate questions in the proposal shall be the basis of the Takaful Plan.

إقرار: بما أنني قد تقدمت بطلب منفعة التكافل العائلي على حياتي مع شركة سبب تكافل، بما يتفق مع العرض وبموجب الشروط التي يحويها مثل برنامج التكافل هذا والممنوح خلال البيع بعد ذلك، فإنني أقر بأن كل الإجابات على الأسئلة أدناه صحيحة، وأنتي لم أقم بإخفاء أية معلومات. أنا أفهم بأن هذه الإجابات والإجابات عن الأسئلة المطروحة بشكل منفصل في نموذج العرض سوف تشكل معاً أساساً لبرنامج التكافل.

Signature of the Participant _____ Date _____ التاريخ _____ توقيع المشترك

QUESTIONS TO BE PUT FORTH BY THE MEDICAL EXAMINER

	Yes	No	If the answer is 'Yes', please elaborate
1. Have you or any near relatives either dead or living suffered from epilepsy, diabetes, nervous disorder, stroke, heart disease or any significant condition?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you : a) Suffered from high blood pressure, loss of consciousness, rheumatic fever, arthritis or gout, goitre or any other endocrine disease, bronchitis, asthma or other chest disorder, peptic ulcer, recurring indigestion or bowel disorder, kidney or bladder trouble or any other serious illness or operation or injury?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Any evidence of cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Undergone any special investigation e.g. X-ray, ECG, etc?	<input type="checkbox"/>	<input type="checkbox"/>	
d) Been under treatment, by drugs? (e.g. hypertensive, anticoagulants, steroids, psychotropic drugs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	

QUESTIONS TO BE ANSWERED BY THE MEDICAL EXAMINER

	Yes	No	If the answer is 'Yes', please elaborate
3. a) Are you personally or professionally acquainted with the proposed? If known to you in a professional capacity, please give details of any consultations.	<input type="checkbox"/>	<input type="checkbox"/>	
b) What is the general appearance of the proposed (healthy, obese, muscular, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Does the proposed smoke? Please give details of past and present smoking habits.	<input type="checkbox"/>	<input type="checkbox"/>	
d) Is there any reason to suspect intemperate habits	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you find any evidence of past or present disease or abnormality of:			
a) Heart or blood vessels			
i) Is there any arcus, xanthoma or any other stigma of vascular abnormality	<input type="checkbox"/>	<input type="checkbox"/>	
ii) Is there any evidence of arteriosclerosis or aneurysm, hypertrophy, oedema or heart murmur? If murmur is present, please describe.	<input type="checkbox"/>	<input type="checkbox"/>	
iii) Does the proposed suffer from pericardial pain, breathlessness on slight exertion or any symptoms of impaired cardiac.	<input type="checkbox"/>	<input type="checkbox"/>	
iv) Is the proposed the subject of piles or fistula? If yes, is treatment necessary?	<input type="checkbox"/>	<input type="checkbox"/>	
b) Respiratory System			
(i) Is there any abnormality of the respiratory system to palpation, auscultation, or any sign of past or present respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>	
(ii) Is the shape, capacity and expansion of the chest unsatisfactory?	<input type="checkbox"/>	<input type="checkbox"/>	
(iii) Are there any abnormal signs in the lungs?	<input type="checkbox"/>	<input type="checkbox"/>	
c) Central or peripheral nervous system?			
(i) Is there any abnormal reflex or other evidence of disease of the brain, nerves or spinal cord?	<input type="checkbox"/>	<input type="checkbox"/>	
(ii) Is there any sign or symptom of fits, paralysis, seizure, nervous breakdown or any other mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
(iii) Has there been any history of nervous or mental disorder? If so, of what type and severity.	<input type="checkbox"/>	<input type="checkbox"/>	

QUESTIONS TO BE ANSWERED BY THE MEDICAL EXAMINER

	Yes	No	<i>If the answer is 'Yes', please elaborate</i>
d) Eyes, ears, nose, throat and mouth Is there any defect in sight, hearing or speech or any abnormality of eyes, ears, nose, throat or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
e) Genito-urinary system Is there any evidence of venereal disease, renal stone or disease of reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	
f) Abdomen i) Are there any symptoms of digestive disturbance? ii) Is there any reason to suspect disease of the liver or any other abdominal organ? iii) Is the proposed subject of hernia? If so, what kind, and does he wear a suitable truss?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
g) Skin, bones or joints (i) Any abnormality of the muscles, bones or joints, including the back and neck? ii) Are there any varicose veins, deformities, lameness and amputations?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
h) Others i) Is there any other sign, symptom or abnormality, which has not been expressly mentioned above? ii) Are you of the opinion that the proposed is particularly exposed to the risk of HIV infection?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
5 a) Do you consider that there are any circumstances which would give rise to i) Undue liability to accident or sickness? ii) Lengthened duration of incapacity in the event of disablement?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
b) Do you recommend any additional tests or reports?	<input type="checkbox"/>	<input type="checkbox"/>	
6 Females only a) Has she borne children? If yes, have her confinements been subject to any complications? b) Is she now pregnant? If yes, how far advanced? c) Have you any reason to suspect uterine or ovarian disease? d) Are the breasts abnormal on palpation?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

7 Build - Please measure and weigh the proposed

Height _____ cm Weight _____ kg Chest: insp _____ cm
 Exp _____ cm Abdominal _____ cm (Relaxed and at Umbilicus): Increasing Decreasing Static

If chest expansion is less than 5 cm / 2 in, comment as to apparent cause.

If weight change in past year is more than 4 kgs, comment as to apparent cause.

8 a) Blood Pressure - If over 140 systolic or 90 diastolic, record three readings:

	1st	2nd	3rd
Systolic			
Diastolic 4th Phase			
Diastolic 5th Phase			

b) If the proposed is on hypertensive treatment, please state, if known, the readings with relevant dates:
 (i) Before treatment _____
 (ii) During treatment _____

c) Pulse
 (i) Rate _____
 (ii) Character (if irregular state the nature of the irregularity, whether premature contraction, dropped beats due to heart attack, or the complete irregularity due to atrial fibrillation).

9 Urinalysis - Please test urine and state results

Blood	
Albumin	
Sugar	

10 a) In which of the three following classes would you place the proposed. First Second Third

b) Additional notes and comments _____

c) Please comment on the lab test results, ECG tracing etc, if any: _____

Signature of Examiner _____	Medical Qualification _____
	Name of Clinic _____
	Stamp _____ Date _____