PhillipLife ฟิลลิปประกันชีวิต

บริษัท ฟิลลิปประกันชีวิต จำกัด (มหาชน) (ทะเบียนเลขที่ 0107556000671)
849 อาคารวรวัฒน์ ถนนสีลม แขวงสีลม เขตบางรัก กรุงเทพฯ 10500 โทรศัพท์ : 0-2022-5000 โทรสาร : 0-2022-5500
Phillip Life Assurance Public Company Limited (Registration 0107556000671)
849 Vorawat Bldg., Silom Rd., Bangrak, Bangkok 10500 Tel.: 0-2022-5000 Fax.: 0-2022-5500 www.phillipLife.com

ใบรายงานการตรวจสุขภาพ สำหรับผู้เยาว์ (อายุต่ำกว่า 16 ปี)

คำขอเอาประกันชีวิตเลขที่...กรมธรรม์ประกันชีวิตเลขที่ ....

ชื่อตัวแทน / นายหน้า ....รหัสตัวแทน / นายหน้า ....

MEDICAL EXAMINER'S REPORT IN CONNECTION WITH APPLICATION FOR JUVENILE POLICY

EXAMINATION OF CHILD (Strip child waist) To be completed only in case of children under age of 16 years.

Name of child examined	Identity Card No.	Date of Birth	Age	Sex	Height	Weight
....	....	....	…...	……	…..(cms.)	…....(kgs.)

Details	Yes	No	Details of "Yes" answers. (Identify item)
1.A – Has the child any impairment of physical growth or mental development or peculiar look?	☐	☐	
B – Has the child any deformity or lameness?	☐	☐	
C – Has the child been hospitalized? When? Where? Why?	☐	☐	
2.After careful inquiry and examination, do you find any evidence of past or present disease or abnormality of:			
A – EENT (Including impairment of sight or hearing?)	☐	☐	
B – Thyroid gland, other endocrine glands, metabolic or blood disease?	☐	☐	
C – Heart or lungs?	☐	☐	
D – Abdomen, kidneys or genito-urinary system?	☐	☐	
E – Brain or nervous system? Convulsion?	☐	☐	
F – Skin, bones, joints or muscles?	☐	☐	
3.Is the child normal and healthy in your opinion?	☐	☐	
Any weight change in the past 6 months?	☐	☐	

4.**For female applicant only**, the last menstruation duration was on date ……………………………….….. to date ………..…………………….………….

5.Urinalysis (Age over 5 years only)

Appearance	pH.	Sp. gr.	Albumin	Sugar	Blood	Others

Additional remarks: (State anything discovered by you, not fully set forth above, which may influence the risk.)

....

....

Date……………………………………Time …………………………………A.M./P.M.

Hospital/Clinic …………………………………………………………………………

Signature ……………………………………………………………MD

(……………………………………..……………………….)

Medical Practitioner Registration No.…………………………….

Hospital/Clinic Stamp Here

ข้าพเจ้าขอรับรองว่าเป็นผู้ปกครองของผู้เยาว์ และได้นำผู้เยาว์นี้มารับการตรวจจากแพทย์จริง

เขียนที่ ....จังหวัด ....วันที่ ....

ลงชื่อ ....ผู้ปกครอง ความสัมพันธ์ ....

(..)

ในกรณีที่ซื้อสัญญาเพิ่มเติมผลประโยชน์ผู้ชำระเบี้ยประกันภัย ผู้เซ็นชื่อในฐานะผู้ปกครองควรเป็นบุคคลเดียวกันกับผู้ชำระเบี้ยประกันภัย

EXAMINATION OF ADULT APPLICATION (This part to be completed only when payor benefit provision is applied for)

Name of Applicant	Height (in low shoes) ………. (cms)	Weight (without coat) ……….. (kgs)	Chest (force inspiration) ………….(cms)	Chest (force expiration) ………..(cms)	Abdomen (at umbilicus) ………..(cms)

BLOOD PRESSURE (if over 140 systolic or 90 diastolic , record 3 readings)

	1st reading	2nd reading	3rd reading
Systolic			
Diastolic (5th phase)			

PULSE

	At rest	After exercise 3 minutes later	
Rate/minute			
Irregularities/minute			

Exercise only if irregular pulse, heart murmur or BP over 150/100

Details	Yes	No	Details of "Yes" answers. (Identify Item)
1. A – Are you personally or professionally acquainted with the applicant? If so, how long?	☐	☐	
B – Does the applicant appear unhealthy (such as pale, icteric, edema, etc.) or older than stated age?	☐	☐	
C – Do you suspect any abnormal mentality behavior or alcohol abuse or drug addict?	☐	☐	
D – Are there any identification marks (such as scars, birthmarks, etc.)?	☐	☐	
2.Do you find any evidence of past or present disease or abnormality of :			
A – Eyes, ears, nose, throat and mouth (including impairment of sight or hearing?	☐	☐	
B – Thyroid or other endocrine glands, metabolic or hemopoietic systems?	☐	☐	
C – Breast (mass, surgical scar or mastectomy)?	☐	☐	
D – Respiratory system (lungs, pleura, chest wall)?	☐	☐	
E – Abdomen (including stomach, liver, spleen, hernias)?	☐	☐	
F – Genito-urinary system?	☐	☐	
G – Central or peripheral nervous system (including reflexes, gait, paralysis)?	☐	☐	
H – Skin, bones or joints (including varicose veins, deformities, lameness, amputations)?	☐	☐	
3.**HEART** : Apex Beat located at ………………………………………………………………………………			
Is there any			
A – Arteriosclerosis or aneurysm?	☐	☐	
B – Hypertrophy or edema?	☐	☐	
C – Murmur – (If murmur is present, describe below)?	☐	☐	
Location [ ] apex [ ] base-over……………………..area			
Timing [ ] systolic [ ] diastolic [ ] presystolic			
Intensity [ ] soft [ ] moderate [ ] loud			
Transmission [ ] none [ ] axilla [ ] scapula			
After exercise [ ] absent [ ] decreased [ ] unchanged [ ]increased			
Diagnosis : ………………………………………………………………………………………………………			
Do you suspect any abnormality in the heart or vascular system?	☐	☐	
4.A – Are you aware of any unfavorable features likely to affect his/her longevity			
(i) in the personal or family history?	☐	☐	
(ii) disclosed by your medical examination?	☐	☐	
B – Do you recommend any additional tests or reports?	☐	☐	
5.Do you find or suspect any signs or symptoms related to HIV infection or AIDS. such as			
A – Lymph node enlargement?	☐	☐	
B – Oral candidiasis or oral hairy leucoplakia?	☐	☐	
C – Abnormal skin rash?	☐	☐	
D – Herpes zoster, herpes simplex, psoriasis etc.?	☐	☐	

6.Urinalysis

Appearance	pH.	Sp. gr.	Albumin	Sugar	Blood	Others

If abnormal finding present, please send for microscopic urinalysis, If available.

Date ……………………………………………….….Time…………………….…A.M./P.M.

Hospital/Clinic……………………………………………………….………………………..

Signature ………………………………..……..………………..MD

(……………………………………………………….)

Medical Practitioner Registration No……………………..………

Hospital/Clinic Stamp Here