



(Not a part of the Application for Insurance)

To The Physician:

The questions on the reverse side must be completed and signed before you. You must ask the Proposed Insured each question and record the answer.

- 1. Name of Proposed Insured:
2. NRIC/SSN/Passport No.:
3. Amount of Insurance: \$
4. Height: Ft. In.
5. Weight: Lbs. Did you weigh?
6. Males Only
A. Chest Expanded In.
B. Chest Contracted In.
C. Abdomen In.

- 12. Any evidence of or disorders of the:
A. BRAIN, NERVOUS SYSTEM?
B. EARS, NOSE, EYES, THROAT, TEETH OR GUMS?
C. THYROID OR LYMPH GLANDS?
D. HEART, BLOOD VESSELS?
E. LUNGS?
F. STOMACH OR ABDOMINAL ORGANS?
G. GENITO-URINARY SYSTEM?
H. SKIN OR EXTREMITIES?

7. Blood Pressure Obtain 3 Readings
Table with 3 columns: Systolic (mm), Diastolic (mm), and 3 rows for 1st, 2nd, and 3rd readings.

8. Pulse Rate per minute. Irregularities Yes No Give number per minute

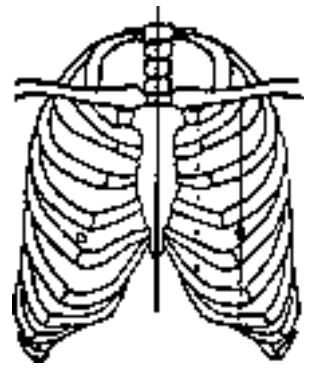
9. Have you ever seen the Proposed Insured professionally before? If "Yes", give details. Yes No

10. Are you in any way related to the Proposed Insured or Solicitor? Yes No

11. Name of Solicitor requesting examination:

- 13. TO BE COMPLETED IF QUESTION 12D IS ANSWERED "YES".
A. Is there a history of rheumatic fever, chorea, scarlet fever, diphtheria, recurrent tonsillitis, syphilis?
B. Is there a murmur? Timing Intensity Quality
C. Is the murmur constant or inconstant?
D. On exercise, does the murmur intensify, decrease, or disappear?
E. Show location of murmur

- Apex by
Area of murmur by outline
Point of greatest intensity
Transmission



F. Apex beat is cm. to left of midsternal line in the interspace.

INSTRUCTIONS

No examiner has any authority to issue a certificate of health or to declare the Proposed Insured acceptable for insurance. Under our rules, only the Company's underwriting department has authority to determine the insurability of the applicants for insurance.

Complete all questions above.

Mail the specimen for laboratory analysis to the laboratory listed on the collection kit or as instructed by your paramedical company.

EXAMINATION WAS MADE IN PRIVATE AT:
My Office
Residence of Proposed Insured
Place of Business of Proposed Insured.
At AM/PM on Date (mm/dd/yyyy)

SIGNATURE OF EXAMINER
Print Full Name
Address

When completed mail to: Transamerica Life (Bermuda) Ltd. Singapore Branch Office 1 Finlayson Green #13-00 Singapore 049246 Co. Reg. No. F 06768D