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บริษัท ชับบ์ ไลฟ์ แอสชัวรันซ์ จำกัด (มหาชน)
ทะเบียนเลขที่ 0107555000431 เลขประจำตัวผู้เสียภาษี 0107555000431
130-132 อาคารสินธร ทาวเวอร์ 1 ชั้น 11-12 ถนนวิทยุ แขวงลุมพินี เขตปทุมวัน กรุงเทพฯ 10330
โทร. 1283 โทรสาร 0-2675-3818 http://life.chubb.com/th

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

(To be used only in case of children under age of 16 years)

PART 1 EXAMINATION OF CHILD (Strip child to waist)

Full name of child examined ☐ Male ☐ Female	Date of birth	Height (cms.)	Age
	Agent's name and code	Weight (kgs.)	Race

If the answer is "Yes", Please identify more of details

1. A. Has the child any impairment of physical growth or mental development or peculiar look?
   ☐ No ☐ Yes Please identify.....
   B. Has the child any impairment of sight or hearing? ☐ No ☐ Yes.....
   C. Has the child any deformity or lameness? ☐ No ☐ Yes.....
   D. Has the child been hospitalized? ☐ No ☐ Yes When? Where? Why?.....
   .....

2. After careful inquiry and examination, do you find any evidence of past or present illness of :
   A. Brain or nervous system? Convulsion? ☐ No ☐ Yes.....
   B. Heart or lungs? ☐ No ☐ Yes.....
   C. Abdomen, Kidneys or urinary tract? ☐ No ☐ Yes.....
   D. Bones, joints or muscles? ☐ No ☐ Yes.....
   E. Eyes, ears, nose, throat, skin, glands or other parts of the body? ☐ No ☐ Yes.....
   F. Endocrine or other diseases? ☐ No ☐ Yes.....

3. Are you satisfied as to Child's identity?.....

4. Is the child normal and healthy in your opinion? (Any weight change in the past 6 months?)
   .....

5. Urinalysis (Age over 5 years) Albumin.....Sugar.....

ข้าพเจ้าขอรับรองว่าเป็นผู้ปกครอง และได้นำผู้เยาว์นี้มารับการตรวจจากแพทย์จริง

ลงชื่อ.....ผู้ปกครอง
( )

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

I certify that I have carefully made this examination at.....
(Address)

On date (dd/mm/yyyy).....Time (HH.MM).....AM/PM

.....M.D.
Medical Examiner

DOCTOR - PLEASE CHECK YOUR REPORT OF OMISSIONS

(This side to be completed only when Payer Benefit Provision is applied for)

PART 2 EXAMINATION OF ADULT APPLICANT (examine heart and lungs on bare skin)

Name of Applicant ☐ Male ☐ Female	ID Card No.	Date of Birth	Age	Relationship of Applicant to child

Height (in low shoes) cm.	Weight (without coat) kgs.	Chest (force inspiration)	Chast (force expiration)	Abdomen (at umbilicus)

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

Systolic			
Diastolic (5th phase)			

PULSE

	At Rest	After Exercise	3 Minutes Later
Rate Per Minute			
Irregularities Per Minute			

URINALYSIS : Specific Gravity	Albumin	Sugar

1. A. Is applicant's general appearance physically and mentally healthy? ☐ No ☐ Yes.....
   B. Does Applicant appear older than age given? ☐ No ☐ Yes.....
   C. Is there any impairment of sight or hearing? ☐ No ☐ Yes.....
   D. Are pupillary and patellar reflexes normal? ☐ No ☐ Yes.....

2. After careful inquiry and examination, do you find any evidence of past or present diseases of:
   A. Brain or nervous system? ☐ No ☐ Yes.....
   B. Heart, lungs or blood pressure? ☐ No ☐ Yes.....
   C. Alimentary System? ☐ No ☐ Yes.....
   D. Genito-Urinary system, breast mass? ☐ No ☐ Yes.....
   E. Bones, joints or muscles? ☐ No ☐ Yes.....
   F. Eyes, ears, nose, throat? ☐ No ☐ Yes.....
   G. Endocrine, skin, glands or other parts of the body? ☐ No ☐ Yes.....

3. A. Has he/she ever had treatment of DM of Hypertension or any chronic illness? ☐ No ☐ Yes.....
   .....
   B. Has he/she received any operation or hospitalization in the past 5 years? ☐ No ☐ Yes.....
   .....

4. FOR FEMALE APPLICANT ONLY
   A. Is she now pregnant? (L.M.P.?) ☐ No ☐ Yes.....
   B. Have her menstruations, pregnancies and labors been normal? ☐ No ☐ Yes.....
   C. Has she ever had any disease peculiar to her sex? ☐ No ☐ Yes.....

5. Do you consider the risk as Excellent, Good, Fair or Poor? (If fair or poor give reasons).....

6. Identification marks.....
   .....

Additional remarks: State anything discovered by you, not set forth fully above,

which may influence the risk :.....

.....

.....

Applicant's Signature

I certify that I have made this examination in private at (Address).....

On date (dd/mm/yyyy).....Time (HH:MM).....AM/PM

.....M.D.

Medical Examiner