

## 9 Data Protection

Cim Life Limited is registered as Data Controller under the Data Protection Act 2004 (Act). In the performance of its business, all the personal data collected and processed (including the sensitive data) will be treated in strictest confidence. We will use our best efforts to ensure that data is accurate, complete, current and reliable for its intended use.

Supply of information in the form is mandatory. To this end, the use of personal information may include sharing the information with other persons or bodies, such as our intermediaries, other insurance companies, surveyors, investigative agents, reinsurers, actuaries, regulatory institutions, fraud and money laundering investigating institutions, whether in Mauritius or another country

The personal data provided may be used for data sharing by Cim Life Limited with other Cim Group companies to advise of, offer and supply other goods and services, for other marketing purposes in a way that is compatible with Data Protection and Privacy Policy (Privacy Policy). It will not however, be presented to a third party (unless otherwise stated in the form or required by law) without your specific authorisation to do so. This exercise excludes the sensitive data.

By signing the form, you are agreeing that your personal data may be processed in the manner hereinabove described. If at any time subsequent changes occur to your personal data or you have any enquiry relating to our Privacy Policy, you can send them in writing to our Compliance Manager.

## 10 Declaration by the Person whose Life is to be assured

I declare and warrant that this Personal Statement is complete and true and also that I understand and agree that this statement, together with the proposal for assurance on my life and any other related documents, shall be the basis of the proposed contract of assurance and any concealment, withholding or misstatement of material fact in answering the above questions will invalidate the assurance on my life.

Date : ..... Signature : .....

# Proposal Form



## Personal Statement made before a medical examiner of the Company

### 1 - Proposer

|                             |  |                          |                  |
|-----------------------------|--|--------------------------|------------------|
| Surname :                   |  | Maiden Name :            |                  |
| First Names :               |  |                          |                  |
| Title : Mr/Mrs/Ms/Dr Other: |  | Sex: Male/Female         | Marital Status : |
| Address :                   |  |                          |                  |
|                             |  |                          |                  |
| Email Address :             |  |                          |                  |
| Tel No Res :                |  | Off :                    | Mob :            |
| Date of Birth :             |  | National Identity Card : |                  |
| Occupation :                |  |                          |                  |
| Proposal : Single / Joint : |  | Place of Birth :         |                  |

### 2 - Medical History

Do you or have you ever experienced any of the following

a) Respiratory or lung problems(e.g:Asthma, recurrent bronchitis, persistent coughs, tuberculosis, shortness of breath)?  Yes  No

b) Any disorder of the heart, blood vessels or circulatory system(e.g.: high blood pressure, chest pain, heart murmurs, palpitations, coronary thrombosis, tightness of chest, shortness of breath, stroke, raised cholesterol or rheumatic fever)?  Yes  No

c) Disease or disorder of the digestive system and /or liver(e.g: stomach ulcers, gall stones, hepatitis, rectal bleeding, gastric or duodenal ulcer, recurrent indigestion or jaundice)?  Yes  No

d) Any nervous or mental complaints(e.g:fits ,depression concussion, unconsciousness,anxiety, stress related disorders, persisitent headaches, epilepsy, blackouts or paralysis)?  Yes  No

e) Disease or disorder of the kidneys or bladder (e.g:kidney-stones, infections, blood or albumin in urine, prostritis, trouble to pass urine or veneral disease)?  Yes  No

f) Problems related to the breasts or reproductive organs?(e.g:If female: ovary or womb problems, miscarriages, premature labour, abortions or breasts lumps. If male:prostate or testicle problem)?  Yes  No

g) Any disorder or disease of skin, spine, joints, muscle, bones, limbs (e.g:backache, slipped vertebrae/disc prolapse, rheumatism, arthritis, gout or any other back or neck trouble)?  Yes  No

h) Diabetes, thyroid, spleen problems or blood disorders?  Yes  No

i) Cancer, growths or tumours of any kind?  Yes  No

j) Been tested for Aids or any Aids-related illness, for Hepatitis B or any other sexually transmitted disease?  Yes  No

k) Have you been admitted to hospital or seen a specialist in the last 5 years?  Yes  No

l) Any other diseases or disorder, operations, disabilities or accidents not mentioned above?  Yes  No

- m) *Applicable for Female:* (1) Are you currently pregnant?  Yes  No  
 (2) Have there been any problems with previous confinements?  Yes  No  
 (3) Have any of your children suffered from any birth defects or congenital abnormalities?  Yes  No
- n) Do you have any genetic disease, e.g: porphyria etc?  Yes  No
- o) Eye, ear, nose, or throat disorder, e.g defective vision, hearing loss, ear discharge, hoarseness?  Yes  No
- q) Have you ever received medical advice to reduce or discontinue liquor, drug or tobacco consumption or has there been a change in consumption?  Yes  No
- r) Is any future surgery planned or do you expect to seek medical advice that you are aware of now in the next eight weeks?  Yes  No
- s) Have you been requested to undergo any medical tests currently?  Yes  No
- t) Have you taken any course of sedatives, tranquilisers, or drugs for medical or other reasons?  Yes  No  
 Please state present or past medication, dosage and reasons for use.

*If any of the above questions are answered in the affirmative, please provide details below.*

| Quest No | Condition | Treatment | Date of last Symptoms | Name & Address of Doctor |
|----------|-----------|-----------|-----------------------|--------------------------|
|          |           |           |                       |                          |
|          |           |           |                       |                          |
|          |           |           |                       |                          |

➤ **3 - Previous Proposals**

- 3.1 Is Your Life already insured with any other insurer?  Yes  No  
 If YES, please specify sum assured and insurance company:.....
- 3.2 Has a proposal for life, disability or accident insurance on your life ever been declined, deferred, or accepted on special terms(e.g. a premium loading etc...)?  Yes  No  
 If YES, please provide details:.....
- 3.3 Have you completed any medicals for any other insurance company in the last 12 months?  Yes  No  
 If YES, please provide details:.....

➤ **4 - Occupation**

Full details of Occupation:.....

Name and address of Employer:.....

.....

.....

.....

➤ **5 - Habits**

- 5.1 Has your height & weight altered by more than 5 kg over the past 5 years  Yes  No  
 If Yes, please provide details:.....
- 5.2 What and how much do you smoke per day?.....
- 5.3 What kind and quantity of alcoholic liquor do you consume per day/week?
- 5.4 Have you ever been charged with drunken driving?  Yes  No

➤ **6 - Activities**

Do you partake in any hazardous pursuit, e.g: Parachuting, hand-gliding, diving, mountaineering, private aviation etc?  Yes  No

If Yes, please provide details:.....

➤ **7 - Family History**

|          | If Living |                | If Dead      |                |
|----------|-----------|----------------|--------------|----------------|
|          | Age       | Sate of Health | Age of Death | Cause of Death |
| Father   |           |                |              |                |
| Mother   |           |                |              |                |
| Brother  |           |                |              |                |
| Sisters  |           |                |              |                |
| Children |           |                |              |                |

If not already stated, has any close blood relative had diabetes, heart disease, high blood pressure, mental illness, porphyria or any other hereditary disease?  Yes  No

If Yes, please state full details:.....

➤ **8 Other Circumstances**

Are there any circumstances not disclosed above which may affect the risk of an assurance on your life  Yes  No  
 If YES, please state full particulars:.....

**PART II**  
**MEDICAL EXAMINER'S CONFIDENTIAL REPORT**

PLEASE NOTE : In order to avoid any embarrassment, the results of this examination are not to be disclosed to the applicant or any other unauthorised person. If treatment or investigations are urgently required, please refer the applicant to his personal medical attendant.

Please do not arrange for further additional examinations unless prior consent is obtained from the company.

**EXAMINATION**

**Build and Physical Condition**

- 10.1 Height (without shoes)..... Weight in clothes.....
- 10.2 Chest (insp.).....(exp).....Abdomen.....
- 10.3 State your impression of the general appearance of the applicant.....  
(e.g flabby, thin, muscular, pale, flushed, etc)
- 10.4 Any operation scars or skin lesions?  Yes  No
- 10.5 Signs of hyperlipaemia e.g arcus senilis, xanthomata, xanthelasma etc?  Yes  No
- 10.6 Enlarged thyroid or lymphatic glands, breast lump or other tumour as per palpation?  Yes  No
- 10.7 Any hernia or varicose veins?  Yes  No
- 10.8 Signs of ear disease?  Yes  No
- 10.9 Any deformity or physical abnormality?  Yes  No
- Describe in detail adverse findings and state whether operative or other treatment is required

.....

.....

.....

**Cardiovascular System**

- 11.1 Blood pressure (to be taken in recumbent posture and exact reading to be given)
- Systolic.....mm Hg                      Diastolic.....mm Hg
- 11.2 If the B.P is above 140/90 record a second reading preferably at the end of examination
- Systolic.....mm Hg                      Diastolic.....mm Hg
- 11.3 State of peripheral pulses:                      Rate.....
- Are the peripheral pulses readily palpable?  Yes  No
- 11.4 Are there symptoms and signs of any cardiovascular abnormality e.g. signs of cardiac enlargement cardiac failure, murmurs, abnormal heart sounds or arrhythmia?  Yes  No

Describe fully:

.....

.....

.....

**Respiratory System**

- 12.1 Any abnormality or pain?  Yes  No
- 12.2 Is there any indication of past or present disease?  Yes  No

Describe fully any abnormality detected such as deficient air entry, abnormal character of breath sounds or adventitious sounds

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.....

.....

**Gastro-Intestinal System**

- 13.1 Is there any significant abnormality of the mouth or throat e.g. ulcer, tumor or leukoplakia?  Yes  No
- 13.2 Is there any indication of disease of the gastrointestinal system, liver or spleen?  Yes  No

Describe fully any unhealthy condition, tenderness, palpable mass or other abnormality detected:

.....

.....

.....

**Central Nervous System**

- 14.1 Are the sight (other than refractive errors) hearing, speech and gait normal?  Yes  No
- 14.2 Are there any symptoms of nervous disease?  Yes  No

Describe fully any evidence of disease of the central nervous system:

.....

.....

.....

**Genito-Urinary System**

- 15.1 Comment fully on the history of genito-urinary abnormalities  
(Rectal or vaginal examinations are not necessary and will be called for only in special circumstances)
- .....
- .....
- 15.2 Urine examination (specimen must be voided in surgery)
- 15.2.1 Is protein present?  Yes  No
- 15.2.2 Is glucose present?  Yes  No
- 15.2.3 Is urobilinogen present?  Yes  No
- 15.2.4 Is blood present?  Yes  No
- 15.2.5 Is there any other abnormal finding?  Yes  No

Describe quantity, if present:

.....

.....

- 15.3 State exactly what method was used to test the urine. State the brand name of the test strips used.

.....

.....

**General**

16.1 Is the applicant known to you?  Yes  No

If "YES", in what capacity, for how long and mention relevant consultations

.....

16.2 Do you know of or suspect any other factors regarding past or present health or habits (alcohol, tobacco, drugs etc) which may influence the assured's life expectancy or ability to follow his/her chosen occupation?  Yes  No

Please comment fully

.....

.....

16.3 Would you advise any special examinations (e.g. blood tests, chest X-rays, lung function tests, cardiologist or neurologist opinion, etc) to clarify any points arising from your examination?  Yes  No

If so, state which examination and why you advise it.

.....

.....

16.4 Have you any specialist's reports or results of previous investigations?  Yes  No

Please include or comment on these. (The reports will be returned to you).

.....

.....

.....

**Additional Notes**

| Questions Nos | Details |
|---------------|---------|
|               |         |

Please send this confidential report without delay direct to **Cim Life Limited, 22 St Georges Street, Port Louis**

Dated at.....this.....day.....of .....

Name of Medical Examiner:.....

**I certify having examined the applicant after identifying him/her through his/her identity card.**

Examiner credited

.....

(Signature of Medical Examiner)