

# Well-being benefit

## Medical Examination Report Form

Please complete this form and return it to:

William Russell Limited,  
William Russell House, The Square, Lightwater, Surrey GU18 5SS. UK.  
Tel: + 44 (0) 1276 486455 Fax: + 44 (0) 1276 486466 E-mail: claims@william-russell.co.uk

**Please read these instructions carefully.**

**Section A and B of this Form must be completed by the insured person.** It is important that you give a clear answer to each question.

**In Section B please list the bills for which you are claiming reimbursement and attach these original bills.** Please note that photocopies of bills are not acceptable. We cannot reimburse a photocopied bill.

**Section C must be completed by the medical doctor who examines you.** Please ensure that the physician gives complete answers to all the relevant questions. Please also ensure that we have the physician's address and contact numbers.

**Claims must be submitted within 6 months of the examination.** Failure to submit your claim within this 6 month period will invalidate your claim.

### SECTION A - TO BE COMPLETED BY THE INSURED PERSON

Full name of Global Health policy holder:

Full name of person for whom the Well-being benefit is being claimed:

Global Health Plan policy number: Date of birth: Sex:  Male  Female Title: Mr/Mrs/Miss/Ms/Dr

Full mailing address:

Telephone: Fax: E-mail:

Please state the name and address of your personal physician (General Practitioner):

Telephone: Fax: E-mail:

### SECTION B - PLEASE LIST THE BILLS FOR WHICH REIMBURSEMENT IS BEING CLAIMED AND STATE HOW YOU WISH TO BE REIMBURSED.

PLEASE ATTACH THE ORIGINAL, FULLY ITEMISED ACCOUNTS. PHOTOCOPIES ARE NOT ACCEPTABLE.

Date(s) of examination	Details of the bills you have enclosed for reimbursement PLEASE ENSURE THESE BILLS ARE ENCLOSED	Enclosed	Please state the currency and the amount(s) paid
	Medical Examination Report	YES/NO	
	Cervical smear test	YES/NO	
	Mammogram	YES/NO	
	Prostate cancer test	YES/NO	

Our preferred method of settlement is direct to your bank account. If you would like us to make settlement in this way please complete your bank details here:-

Account Name:	Account Number:
Bank Name:	Sort or Swift Code:
Bank Address:	
Currency of Settlement:	

If you would prefer settlement by cheque or draft, please give your instructions here:-

Method of settlement:	<input type="checkbox"/> cheque <input type="checkbox"/> draft
Currency*:	
Payee:	
Other instructions:	

\*Unless we are advised otherwise, settlement of your claim will be made in the currency of your policy.

### Declaration and authorisation by the claimant

I hereby declare that the above answers are true and complete and I hereby give permission to the Insurer or their representative to contact the physician direct should they need to do so. I also agree to supply any additional information that may be required.

Signature of claimant:

Date:

## THE MEDICAL EXAMINATION

This questionnaire details the medical examination covered by the Well-being benefit. No other tests are covered.

Please ask the physician who performs the medical examination to complete the following medical questionnaire whilst he or she carries out the medical examination.

### SECTION C - MEDICAL EXAMINATION

Dear Doctor,

Our client's Global Health plan provides benefit toward the cost of a routine annual medical examination. Please could you examine our client and state the answers to all of the questions. Please also indicate all pathological or abnormal findings in the spaces provided below:-

FULL NAME OF PATIENT

DATE OF EXAMINATION

day	month	year
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HEIGHT & WEIGHT

Height (without shoes)

 cm

Weight

 kg

SKIN

Are there any signs of skin disease  
(e.g. rash, ulcer, swelling etc)?

Yes/No

Are there any scars, suspicious naevi?

Yes/No

RESPIRATORY ORGANS

Is there any hoarseness or coughing?

Yes/No

Is there any abnormality in the shape and curvature  
of the thoracic cage?

Yes/No

Are the results of percussion and auscultation abnormal?

Yes/No

Are there any other signs of disease of the respiratory  
organs present?

Yes/No

DIGESTIVE ORGANS AND ABDOMEN

Are there any abnormalities of the tongue, tonsils,  
mucous membrane or throat?

Yes/No

Are there any abnormalities on examination,  
palpation and percussion of the abdomen (stomach,  
liver, gall bladder, aorta, spleen, intestines)?

Yes/No

Are there any signs of disease of the digestive system?

Yes/No

Is a hernia present?

Yes/No

MUSCULOSKELETAL SYSTEM

Are there any deformities?

Yes/No

Are there signs of spinal disease?

Yes/No

Are there muscular, bone or joint diseases?

Yes/No

**SECTION C - MEDICAL EXAMINATION (CONTINUED)**

**HEART AND CIRCULATION**

Is the apex beat displaced? Yes/No

Are the heart sounds abnormal (intensity, split)? Yes/No

Is there a heart murmur? Yes/No

If yes, Systolic? Yes/No

Diastolic? Yes/No

Point of maximum intensity and transmission? Yes/No

Is the heart murmur organic? Yes/No

Blood pressure, pulse rate

Beats per minute	Blood pressure in mmHg	
<input type="text"/>	systolic	diastolic
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please repeat if the result is over 140/90mmHg

2nd reading		
systolic	diastolic	
<input type="text"/>	<input type="text"/>	<input type="text"/>

Is the pulse irregular? Yes/No

Is pulsation of the pedal arteries absent or diminished? Yes/No

Bilaterally?

Are there audible vascular sounds? Yes/No

Are there any signs of insufficiency or decompensation (shortness of breath, cyanosis, oedema)? Yes/No

Are there any varicose veins? Yes/No

Severity, extent, ulcers, scars?

**UROGENITAL ORGANS**

Urinalysis: Presence of albumin? Yes/No

Presence of sugar? Yes/No

If yes, please quantify

Sediment? Please give reading.

RBC	WBC	other
<input type="text"/>	<input type="text"/>	<input type="text"/>

For males:

Is there any suspicion of disease of the urogenital organs (testicles, epididymis, prostate)? Yes/No

For females:

Is there any suspicion of disease of the urogenital organs or pathological breast abnormality? Yes/No

## SECTION C - MEDICAL EXAMINATION (CONTINUED)

### NERVOUS SYSTEM/SENSE ORGANS

Are there any signs of disease of the sense organs, particularly diminished sight or hearing? Yes/No

Are there any abnormal reflexes (i.e. pupillar, abdominal, patellar, achilles tendon, Babinski)? Yes/No

Is there any evidence of mental or nervous system abnormalities? Yes/No

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### DIVERSE

Are there any enlarged lymph nodes? Yes/No

Is the thyroid gland abnormal in size or texture? Yes/No

Are there any signs of hormonal imbalance (e.g. adrenal glands, gonads, thyroid gland)? Yes/No

Are there any other abnormal findings? Yes/No

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### FINAL EVALUATION

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ARE ANY FURTHER INVESTIGATIONS NECESSARY? IF YES, PLEASE STATE HERE.

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## PLEASE COMPLETE YOUR NAME AND ADDRESS HERE

Full name of examining physician
Full address
Telephone number:
E-mail address:

Physician's stamp
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## PHYSICIAN'S DECLARATION

I hereby confirm that I have questioned and examined the insured person and have answered the above questions to the best of my knowledge and in good faith.

Signature
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Date
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PLEASE HAND THE COMPLETED QUESTIONNAIRE TO THE PATIENT TOGETHER WITH YOUR BILL FOR THIS MEDICAL EXAMINATION