

MEDICAL EXAMINER'S REPORT

1. Name of Proposed Insured:				Date of Birth: / / Mo. Day Yr.	
2. a. Height (In Shoes) ___Ft. ___in.	Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Weight (Clothed) _____lbs.	Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of "Yes" items. Include details of adverse findings. (Identify each item)	
3. a. Chest (Full Inspiration) ___in.	b. Chest (Forced Expiration) ___in.	c. Abdomen, at Umbilicus ___in.			
4. Blood Pressure (if above 140/90, report readings below)					
Systolic					
4th Phase					
5th Phase					
Diastolic					
5. Pulse: Rate: Irregularities per Minute:	At Rest	After Exercise	3 Minutes Later		
6. a. Is there a murmur? If yes, what type of murmur is found? (If no, go to Question #7)				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Timing: <input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic Intensity: <input type="checkbox"/> Faint <input type="checkbox"/> Moderate <input type="checkbox"/> Loud Quality: <input type="checkbox"/> Soft <input type="checkbox"/> Blowing <input type="checkbox"/> Rough					
c. Are S1 and S2 preserved?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Is the murmur altered with maneuvers?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. On exercise, does the murmur: <input type="checkbox"/> Intensify? <input type="checkbox"/> Decrease? <input type="checkbox"/> Disappear?					
f. Is the Point of Maximum Intensity (PMI) displaced?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. After careful inquiry and upon examination, is any evidence of past or present abnormality, disease or disorder of the following found: (Circle all applicable items and provide full details)				8. Urinalysis: (dipstick method is adequate)	
a. Eyes, ears, nose, mouth and pharynx? (if vision or hearing markedly impaired, indicate degree & correction)				<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Skin (incl. scars; lymph nodes, veins or peripheral arteries)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Nervous system (incl. reflexes, gait, paralysis)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Is there any history of rheumatic fever, chorea, scarlet fever, recurrent tonsilitis, diphtheria or syphilis?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Respiratory system?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Abdomen (incl. scars)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Genitalia (males only)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Endocrine system (incl. thyroid and breasts)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Musculoskeletal system (include spine, joints, amputations, deformities)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Urinary system or hernias, hemorrhoids?				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature of Proposed Insured:	Date:
Signature of Medical Examiner:	Date:
Print Name of Medical Examiner:	
Address of Medical Examiner:	

City	State	Zip Code	Examiner's Telephone Number
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Return fully completed form to:
HCC SPECIALTY UNDERWRITERS, INC.
401 Edgewater Place, Suite 400, Wakefield, MA 01880
Phone: 781-994-6000 Fax: 781-994-6001

HCC SPECIALTY UNDERWRITERS, INC.
401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880

AUTHORIZATION FORM

Name of Proposed Insured: _____
(Please **print** in black ink)

IT IS UNDERSTOOD AND AGREED AS FOLLOWS:

1. No agent, broker or medical examiner has authority to waive or withhold the answers to any questions to determine insurability or to waive any of the Insurer's and/or the Company's rights or requirements, or to make or alter any contract, or policy or certificate.
2. The Insurer and/or the Company has the right to require medical exams and tests to determine insurability and is authorized to obtain investigative consumer, financial and/or medical or other report(s).

AUTHORIZATION TO OBTAIN INFORMATION

To all physicians; medical professionals; hospitals; clinics other health care providers and facilities; insurers; employers; Medical Information Bureau (MIB); consumer reporting agencies; financial institutions; other insurance support organizations; and any other person(s) (including lawyers and accountants), who have information about the Proposed Insured:

I authorize you to give the Insurer and/or the Company, its authorized representatives, or its reinsurers:

- (a) all information you have as to sickness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition, disease, syndrome or disorder of the Proposed Insured; and
- (b) any non-medical information, including but not limited to investigative consumer report(s), which the Insurer and/or the Company believes it needs to perform the business functions as described below.

The information obtained will be used to determine if the Proposed Insured is eligible and/or insurable for:

- (a) the insurance being requested; or
- (b) benefits under a policy and/or certificate which is in force; and
- (c) any other business purpose which relates to the insurance being requested or the policy and/or certificate which is in force.

This Authorization To Obtain Information form will be valid for sixty (60) months. The Proposed Insured may request a copy at any time. The Proposed Insured agrees that a photocopy of this form is as valid as the original.

Date

Signature of Proposed Insured

Witness