

Medical Examiner's Certification Form

For Term Insurance Policies

Applicant's Details

Full Name

Date of Birth

Gender

Policy Number

Date of Examination

Address

Medical Examination Details

Height

Weight

Blood Pressure

Pulse

General Health Comments

Relevant Medical History

Abnormalities or Other Findings

Medical Examiner’s Certification

I hereby certify that I have examined the above-named applicant and the details provided above are accurate to the best of my knowledge.

Medical Examiner’s Signature

Date

Medical Examiner's Name

License Number

Contact Number