MEDICAL EXAMINATION FOR GROUP INSURANCE

PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED

APPLICANT NAME: ____________________

APPLICANT DOB: ____________________ APPLICANT SSN: ____________________

ACCOUNT # from MEYER AND ASSOCIATES (if known; begins with 61 or 62): ____________________

MAILING.ADDRESS: ____________________

NOTE: Any charge for this examination is the responsibility of the Applicant

MEDICAL EXAMINATION

(To be completed by Medical Examiner)

1. **Age**: ___ years **Sex:** ☐Male ☐Female **Measurements:** Height ___ Ft, ___ Inches Weight_____lbs
2. 1st Blood Pressure: _______ / _______ (Systolic / Diastolic) 2nd Blood Pressure: _______ / _______ (Systolic / Diastolic)
3. Is Applicant currently taking ANY prescription drugs, vitamins or over-the counter medications? If yes, please list here: ____________________
4. Pulse _______
5. History of:
   - High Blood Pressure ☐ Yes ☐ No
   - Diabetes ☐ Yes ☐ No
   - Heart Disease ☐ Yes ☐ No
6. If the Applicant is female, is she
   (a) Now pregnant? ☐ Yes ☐ No ☐ Applicant is Male
   (b) Was Applicant menstruating on date of examination? ☐ Yes ☐ No

7. Please supply results of Blood Chemistry and Immunology to include the following results:

IMMUNOLOGY

HIV-1 ANTIBODY (BLOOD) ____________

FULL BLOOD CHEMISTRY RESULTS

Abnormal results? ☐ Yes ☐ No

Test	Units	Result
GLUCOSE	(MG/DL)	____________
BUN	(MG/DL)	____________
CREATININE	(MG/DL)	____________
ALK. PHOS.	(U/L)	____________
BILI. TOT.	(MG/DL)	____________
AST (SGOT)	(U/L)	____________
ALT (SGPT)	(U/L)	____________
GGT (GGTP)	(U/L)	____________
TOT. PROTEIN	(G/DL)	____________
ALBUMIN	(G/DL)	____________
GLOBULIN	(G/DL)	____________
CHOLESTEROL	(MG/DL)	____________
HDL CHOLESTEROL	(MG/DL)	____________
LDL (CALCULATED)	(MG/DL)	____________
CHOL/HDL CHOL RATIO		____________
LDL/HDL RATIO		____________
TRIGLYCERIDES	(MG/DL)	____________
GFR		____________
PRO-BNP		____________

For males over 49 years old

PSA (NG/ML) ____________

Please complete page 2 of this form

When complete, please submit the signed form to Meyer and Associates, the Administrator:

Info@MeyerAndAssoc.com
Fax both sides to 973-635-7578
Click here to upload securely online

MEDICAL EXAMINATION FOR GROUP INSURANCE

PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED

APPLICANT NAME: ______________________ APPLICANT DOB: __ __ ______

APPLICANT SSN: ______________________

NOTE: Any charge for this examination is the responsibility of the Applicant

MEDICAL EXAMINATION

(To be completed by Medical Examiner)

8. Please supply results of Urinalysis to include the following results:

URINALYSIS

☐ Positive ☐ Negative

Test	Unit	Result
GLUCOSE	(GM%)	____________
PROTEIN	(MG%)	____________
LEUKOCYTE SCREEN		____________
HEMOGLOBIN SCREEN		____________
WHITE BLOOD CELL	(/HPF)	____________
RED BLOOD CELLS	(/HPF)	____________
GRANULAR CASTS	(/40LPF)	____________
HYALINE CASTS	(/LPF)	____________
SPECIFIC GRAVITY		____________
URINE TEMP	(FAHRENHEIT)	____________
CREATININE	(MG/DL)	____________
PROT/CREAT	(MG/MGCR)	____________
COCAINE		____________
THIAZIDE		____________
BETA BLOCKER (BAB)		____________
NICOTINE (COTININE)		____________

9. Are you currently the personal physician? ☐ Yes ☐ No

I personally examined this person on this date with the results recorded.

Examiner Name (Printed):	Examiner Title:
Phone Number: (Including Area Code/Country Code)	Date:
Street Address: City: State: Postal/ Zip Code:	Examiner Signature:

Questions? Call 973-635-7800 or 800-635-7801 Weekdays 8:30 am - 6:00 pm ET

When complete, please submit the signed form to Meyer and Associates, the Administrator:

Info@MeyerAndAssoc.com

Fax both sides to 973-635-7578

Click here to upload securely online