

PRESTIGE INSURANCE PATHOLOGY
ABN: 11 487 681 921
Medical & Paramedical Services
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REQUEST FOR MEDICAL & PARAMEDICAL SERVICES

Date: _____ Male: _____ Female: _____
Clients Name: _____ Date of Birth: _____
Address: _____ Postcode: _____
Phone (H) _____ Mobile: _____ Phone (W): _____
Insurance Company: _____ App. No: _____
Agents Name: _____ Phone: _____

TESTS REQUIRED (Please tick)

- | | |
|---|--|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Serum Cotinine |
| <input type="checkbox"/> MBA | <input type="checkbox"/> Resting ECG |
| <input type="checkbox"/> HDL, LDL | <input type="checkbox"/> Paramedical |
| <input type="checkbox"/> Hepatitis B antigen | <input type="checkbox"/> Quick / Fast Check |
| <input type="checkbox"/> Hepatitis C antibody | <input type="checkbox"/> GP Medical |
| <input type="checkbox"/> Micro-urine | <input type="checkbox"/> Specialist Medical with resting ECG |
| <input type="checkbox"/> FBC, ESR | <input type="checkbox"/> Stress (Exercise) ECG |
| <input type="checkbox"/> Other requirements (please indicate) | |

Authorised (ie. Agents) signature

TO BE COMPLETED BY CLIENT AT TIME OF TEST

This section is to be completed, dispatched and returned to the Insurance Company with the results.

I acknowledge that the tests nominated above will be performed. Where one is the presence of antibodies to the AIDS virus, I acknowledge that I have read the material provided by the Insurance Company on the implications of and AIDS test and I understand the significance of the test.

Life Insured's signature: _____ Witness: _____
Date: _____ Date: _____

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