Supplementary Medical Questionnaire
To be completed by the insured life

Application Reference Number

The questionnaire must be completed by the Life Insured.
Important: No compensation is payable if a Medical Examiner completes this questionnaire.

Particulars of Life Insured

First Name(s)

Last Name

Identity No./Passport No.

Date of birth

Address

Particulars of Life Insured

1. Please specify your medical condition:

2. When did your symptoms first occur?

3. Please state the nature of your symptoms. What do you think caused them?

4. Describe the duration and severity of your symptoms.

5. How frequently did they occur? Daily Weekly Monthly Other

If 'Other', please provide full details:

6. Please provide details, including dates, of any examinations or tests that were conducted:

7. What was the diagnosis?

8. What treatment was advised or given? Did you experience any after-effects?

9. Do you continue to experience your symptoms? If so, please state the most recent date when your symptoms occurred.

10. Did you have any functional impairment? Yes No If you have answered 'Yes', please provide full details:

11. Please provide details of any doctor(s) you have seen and the purpose for which they were consulted.
Use continuation sheets if necessary.

Name

Address

Telephone Email

Date and reason for consultation

Name

Address

Telephone Email

Date and reason for consultation

Declaration by Insured Life

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Signature Date