Declaration of Health
(by 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.

Section 1: Particulars of Life Insured

First Name(s)

Last Name

Identity No./Passport No.

Date of birth

Address

Telephone Number

Occupation

Description of main duties

Gross monthly income

Please estimate the percentage of your working hours allocated to the following activities

Travelling | Administration | Supervision | Manual labour | Industry

Employer

Description of main duties

Section 2: Underwriting questions

Please work through questions 1 to 14. If any of the conditions are relevant to you then you should tick the 'Yes' box at the start of the question. If you answer 'Other', a space will be provided for you to list your condition. You must then provide further details in the section on page 3.

Do you currently or have you ever suffered from any of the following?

1 Heart or blood circulation ☐ Yes ☐ No

1.1 High blood pressure	☐	1.4 Raised cholesterol	☐	1.7 Shortness of breath	☐
1.2 Rheumatic fever	☐	1.5 Chest pains	☐	1.8 Heart murmur	☐
1.3 Palpitations	☐	1.6 Heart attack	☐	1.9 irculatory disorders of legs	☐

1.10 Other (please specify)

2 Respiratory and lung complaints ☐ Yes ☐ No

2.1 Asthma ☐ 2.3 Bronchitis ☐ 2.5 Any breathing problems ☐

2.2 Tuberculosis ☐ 2.4 Persistent coughing ☐

2.6 Other (please specify)

3 Disorders of the digestive system, gall bladder, pancreas or liver ☐ Yes ☐ No

3.1 Gall stones ☐ 3.3 Gastric ulcers ☐ 3.5 Hiatus hernia ☐

3.2 Pancreatitis ☐ 3.4 Recurrent indigestion ☐ 3.6 Rectal bleeding ☐

3.7 Hepatitis A/Acute hepatitis/Jaundice ☐ 3.8 History of hepatitis B or C/Chronic hepatitis/Any liver disorder ☐

3.9 Other (please specify)

4 Disorders of the kidneys, bladder or reproductive organs ☐ Yes ☐ No

4.1 Protein in urine ☐ 4.3 Kidney stones ☐ 4.5 Prostate problem ☐

4.2 Blood in urine ☐ 4.4 Bladder infection ☐

4.6 Other (please specify)

5 Have you used any of the following drugs or medicines: ☐ Yes ☐ No

5.1 Sedatives ☐ 5.3 Tranquilisers ☐ 5.5 Anabolic steroids ☐

5.2 Antidepressants ☐ 5.4 Cannabis ☐ 5.6 Cocaine ☐

5.7 Chronic medication other than for disclosed conditions (please specify)

5.8 Any homeopathic medicines ☐

5.9 Other (please specify)

6 Nervous or mental disorders ☐ Yes ☐ No

6.1 Anxiety ☐ 6.3 Depression ☐ 6.5 Stroke ☐

6.2 Epilepsy ☐ 6.4 Blackouts ☐ 6.6 Paralysis ☐

6.7 Panic attacks/Post traumatic stress disorder ☐ 6.8 Consultation/s with psychiatrist/psychologist ☐

7 Any disorders of the eye, ear, nose or throat ☐ Yes ☐ No

7.1 Defective vision (excluding conditions corrected by glasses, contact lenses or keratotomy)

7.2 Hoarseness ☐ 7.3 Ear discharge ☐ 7.4 7.4. Hearing loss ☐

7.5 Other (please specify)

8 Problems with the skin, muscles, bones, joints, limbs or spine ☐ Yes ☐ No

8.1 Psoriasis ☐ 8.5 Dermatitis ☐ 8.9 Back problems ☐

8.2 Arthritis ☐ 8.6 Gout ☐ 8.10 Fractures/Broken bones ☐

8.3 Neck problems ☐ 8.7 Slipped disc ☐

8.4 Fibromyalgia ☐ 8.8 Rheumatism ☐

8.11 Other (please specify)

9 Blood, glandular or hormonal disorders ☐ Yes ☐ No

9.1 Bleeding disorders ☐ 9.3 Diabetes Type 1 ☐ 9.5 Sugar in urine ☐

9.2 Anaemia ☐ 9.4 Diabetes Type 2 ☐ 9.6 Problems with thyroid/other glands ☐

9.7 Other (please specify)

10 Cancer, any growth or tumour of any kind, including moles removed (malignant/benign) ☐ Yes ☐ No

11 To be answered by female Insured Lives only: Do you suffer from any disorder of the female organs (breasts, ovaries, uterus); have you experienced any abnormality of pregnancy or confinement, or do you have any abnormal vaginal bleeding, dense breast tissue, or any lumps or cysts in the breasts or ovaries?

☐ Yes ☐ No

If you have answered 'Yes', please provide further details

12 Do you have any physical or chronic disorders or have you suffered from any tropical disease? ☐ Yes ☐ No

12.1 Chronic fatigue syndrome ☐ 12.4 Do you suffer from any chronic disease? ☐

12.2 Any tropical diseases, e.g. malaria, bilharzia ☐ 12.5 Porphyria ☐

12.3 Do you contract the same illness recurrently? ☐

12.6 Other (please specify)

13 Have you sought medical advice, personal counselling or treatment for any sexually transmitted diseases? ☐ Yes ☐ No

13.1 Gonorrhoea/Syphilis/Genital herpes ☐

13.2 Other (please specify)

14 Have you experienced any other other illness, disorder, disability or accident, including motor vehicle accidents?

☐ Yes ☐ No

If you have answered 'Yes', please provide further details

Further information: If you have answered 'Yes' to any of questions 1 to 14, please provide details, ensuring you note the question number to which you are referring.

Q no	Condition/impairment	Name, address and telephone number of doctor/hospital	Are you currently receiving treatment?	Date of last treatment/ symptoms	Do you consider that you are fully recovered?
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

15 Have any of the following procedures been carried out in the past? (This excludes investigations conducted for any condition you have already disclosed.)

☐ Yes ☐ No

If you have answered 'Yes', please provide further details

15.1 X-rays ☐

15.2 Genetic testing/Tumour markers ☐

15.3 Consultation/s with any specialists ☐

15.4 ECGs ☐

15.5 Scans ☐

15.6 Have you received medical advice? ☐

15.7 Do you have a history of gastroscopy, colonoscopy or has any other special examination been conducted? ☐

15.8 Have you had any operations, or have you ever been hospitalised (excluding for tonsillectomy or appendectomy)? ☐

15.9 Other (please specify)

16 Is any future surgery planned, or are you aware that you expect to seek medical advice within the next eight weeks? (This excludes any medical examinations that may arise from this application.)

☐ Yes ☐ No

If you have answered 'Yes', please provide further details

17 Family history. Do any of your relatives suffer from, or have they had any of the following medical conditions?

☐ Yes ☐ No

	Father		Mother		Brother/ Sister		Brother/ Sister		Brother/ Sister		Brother/ Sister	
Age if alive												
If deceased, age at death												
Heart disease/Stroke/High blood pressure/ Raised cholesterol												
Diabetes												
Cancer												
Other (hereditary diseases)												

Please give details if you ticked any of the conditions listed above, including age at onset for heart disease or diabetes, and type of cancer. If you have ticked 'Other', please specify details of the condition below:

18 Have you ever been tested for, or received any medical advice or personal counselling regarding AIDS, or any infection by one of the HI viruses? The disclosure of previous test results does not necessarily mean that we will refuse you cover. If you answer 'Yes', please give details of all HIV tests you have undergone, including why the test was conducted or the advice was sought.

☐ Yes ☐ No

Reason for the HIV test ☐ Insurance ☐ Employment ☐ Other

If 'Other', please provide full details:

19 Personal habits and lifestyle

19.1 Have you smoked or used any other form of tobacco in the past 12 months? ☐ Yes ☐ No

If 'Yes', please provide full details:

Type	Quantity per day
Cigarettes	
Pipe	
Cigar	
Smokeless tobacco (chew/snuff)	

If 'Other', please provide full details:

19.2 Do you consume any form of alcohol? ☐ Yes ☐ No

If 'Yes', please provide full details:

Type and measure	Quantity per day
Beer (units/bottles)	
Wine (glasses)	
Spirits (tots)	

If 'Other', please provide full details:

19.3 Have you ever received medical advice or participated in a rehabilitation programme to reduce alcohol and/or tobacco consumption?

☐ Yes ☐ No

If 'Yes', please provide full details:

20 Height and weight Please indicate the appropriate units

20.1 Height (without shoes) m /ft Height (without shoes) kg/lbs

20.2 20.2 Has your weight changed by more than 5kg during the past year? ☐ Yes ☐ No

If 'Yes', please give reason:

My weight has changed by kg/lbs

21 Do you participate in or are you involved in any pursuit, avocation or occupational activity that might be considered hazardous?

☐ Yes ☐ No

☐ Racing ☐ Diving ☐ Aviation ☐ Parachuting ☐ Mining ☐ Occupation ☐ Other

Note: If you have selected any of the above, you must complete the Motor Sports, Scuba Diving, Aviation or Occupational Questionnaire as applicable, and send it to us in conjunction with this form.

If 'Other', please provide full details:

22 Has any insurer ever declined, postponed, withdrawn, accepted at any increased premium or reduced cover, or subjected to an exclusion clause any application for insurance you have made?

☐ Yes ☐ No

If 'Yes', please provide full details:

23 Have you ever been medically boarded or have you submitted claims for disability or third party benefits?

☐ Yes ☐ No

If 'Yes', please provide full details:

24 If there is any other information that you consider relevant to your application, please inform us using the space below.

Current/Most recent medical doctor

Medical doctor: Please supply the name of the doctor to whom we may send reasons for health loadings or results of an HIV test.
(Note: Any such information will be sent marked as 'Confidential Correspondence'.)

Name of medical doctor

Telephone

Postal address

Postal code

Section 3: Declaration and Agreements

I accept and understand that I am limiting my right to privacy. However, to enable the assessment of the risks and to assist in considering any claim for benefits under this or any other application for insurance that I have made or that was made for me as the insured life, I authorise the insurer, including the current and future subsidiaries and/or representatives

- to obtain from any person or body, any information needed in connection with this application or the policy. I also authorise and instruct such person to give the said information to the insurer, and
- to share with other insurers that information and any information in this application or in any related policy or other document, either directly or though a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as the insurer or the operators of such database may decide from time to time, and
- to disclose my medical information to any parties that the insurer uses in providing services in connection with the policy.

I acknowledge that I cannot cancel this authorisation and that it will endure after my death.

I declare and confirm the following:

1. This document and any documents that were submitted in connection with it, form the basis of this contract and all information that I have supplied is correct and complete.
2. I undertake to let the insurer know in writing if a change takes place in the health, activities or occupation of the insured life/lives between the date of this application and the starting date of the policy or the acceptance date, whichever occurs last.
3. I acknowledge that the insurer will apply the standard conditions that it normally sets for this type of contract, and where applicable, the rules of the scheme to which this policy belongs, and that only these conditions will bind the insurer and not the representations or undertakings that any person makes or gives.
4. I understand that the insurer will cancel the insurance contract that was issued under this application if the insured life has withheld any important information on this application form, or answered any question/s incorrectly, and that the policyholder will forfeit all premiums paid.
5. I acknowledge that I have read the declaration above, that I fully understand the nature and effect of it and that it will bind me.

Signature

Date