

Application Reference Number

Other

Yes

No

The	auestionnaire	must he	completed	by the I	ife Incured

Important: No compensation is payable if a Medical Examiner completes this questionnaire.

important. The compensation is payable if a medical examinate compensation and goodination.							
Particulars of Life Insured							
Fi	First Name(s)						
Lo	Last Name						
lc	entity No./Passport No.						
D	ate of birth						
Α	ddress						
Information regarding condition							
1	What caused the back ailment?			(Please give a description next to the ailment.)			
•	Injury	Yes	No				
•	Illness	Yes	No				
•	Congenital	Yes	No				
•	Other	Yes	No				
2	2 Date of commencement of back symptoms/back pain						
3	3 What was the nature of the condition?			(Please provide further details on the relevant line.)			
•	Fracture of vertebrae	Yes	No				
•	Lesion of the disc	Yes	No				
•	Muscle injury	Yes	No				
•	Ligament injury	Yes	No				
•	Curvature of the spine	Yes	No				
•	Arthritis	Yes	No				
•	Whiplash	Yes	No				

Cervical (neck) vertebrace or discs between the vertebrace Yes No Thoracic (chest) vertebrace or discs between the vertebrace Yes No Lumbar (lower back) vertebrace or discs between the vertebrace Yes No Sacral (coccyx) vertebrace Yes No Did you undergo any X-rays or MRI scans? Yes No If 'Yes', please provide dates Did the investigation reveal any abnormalities? Yes No If 'Yes', please provide dates What treatment was or is being applied? Please state the date and your present conditions. What treatment was or is being applied? Please state the date and your present conditions. What treatment was or is being applied? Please state the date and your present conditions. It was no was a state the date and your present conditions. Manipulation Yes No Manipulation Yes No Traction Yes No Manipulation Yes No Medication (state type) Yes No Medication (state type) Yes No Cither Yes No Please complete full details for the following questions Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced?	4	4 Which area of the vertebral column was, or is, affected?						
Lumbar (lower back) vertebrae or discs between the vertebrae Sacral (coccyx) vertebrae Yes No Did you undergo any X-rays or MRI scans? If "Yes", please provide dates Did the investigation reveal any abnormalities? Yes No If you have answered "Yes", please provide full details What treatment was or is being applied? Laminectomy Yes No Fusion Yes No Physiotheraphy Yes No Manipulation Yes No Bed rest Yes No Medication (state type) Yes No Medication (state type) Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced?	•	Cervical (neck) vertebrae or discs between the vertebrae					Yes	No
Sacral (coccyx) vertebrae Pes No	•	Thoracic (chest) vertebrae or discs between the vertebrae				Yes	No	
Did you undergo any X-rays or MRI scans? Yes No	•	Lumbar (lower back) vertebrae or	discs between	n the ve	rtebrae		Yes	No
If 'Yes', please provide dates 6 Did the investigation reveal any abnormalities? 7 What treatment was or is being applied? Flease state the date and your present conditions Fusion Fusion Physiotheraphy Manipulation Yes No Manipulation Yes No Bed rest Yes No Medication (state type) Medication (state type) Medication (state type) Medication state full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced?	•	Sacral (coccyx) vertebrae					Yes	No
6 Did the investigation reveal any abnormalities? 7 What treatment was or is being applied? Fusion Physiotheraphy Manipulation Traction Bed rest Medication (state type) Medication still present? How regularly are these symptoms experienced?	5	Did you undergo any X-rays or MRI	scans?				Yes	No
If you have answered 'Yes', please provide full details 7 What treatment was or is being applied? 1 Laminectomy 2 Yes 3 No 4 Fusion 4 Physiotheraphy 4 Yes 5 No 6 Manipulation 7 Yes 7 No 8 Bed rest 7 Yes 8 No 9 Medication (state type) 9 Yes 10 No 10 Medication (state type) 10 Yes 11 No 12 No 13 a corset or neck brace being used? 14 Yes 15 No 16 Please complete full details for the following questions 16 Are your symptoms still present? 17 What treatment was or is being applied? 18 Please complete full details for the following questions 18 Are your symptoms still present? 19 How regularly are these symptoms experienced?		If 'Yes', please provide dates						
7 What treatment was or is being applied? • Laminectomy • Fusion • Physiotheraphy • Physiotheraphy • Manipulation • Traction • Bed rest • Mo • Medication (state type) • Other • Other • Pes • No • Pes • No • Mo • Reserved to reck brace being used? • Pes • No • Please state the date and your present condition of the date and your present condition o	6	Did the investigation reveal any ab	onormalities?				Yes	No
 Laminectomy Fusion Fusion Physiotheraphy Yes No Manipulation Traction Bed rest Medication (state type) Mes No Other Is a corset or neck brace being used? Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	If	you have answered 'Yes', please pr	ovide full deta	ıils				
 Laminectomy Fusion Fusion Physiotheraphy Yes No Manipulation Traction Bed rest Medication (state type) Mes No Other Is a corset or neck brace being used? Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 								
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 Laminectomy Fusion Fusion Physiotheraphy Yes No Manipulation Traction Bed rest Medication (state type) Mes No Other Is a corset or neck brace being used? Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 								
 Fusion Physiotheraphy Yes No Manipulation Yes No Traction Bed rest Yes No Medication (state type) Yes No Other Is a corset or neck brace being used? Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	7	What treatment was or is being ap	plied?		(Please stat	e the do	ate and your	present condition.)
 Physiotheraphy Manipulation Traction Bed rest Medication (state type) Medication (state type) Other Is a corset or neck brace being used? Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Laminectomy	Yes	No				
 Manipulation Yes No Bed rest Yes No Medication (state type) Yes No Other Is a corset or neck brace being used? Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Fusion	Yes	No				
 Traction Yes No Bed rest Yes No Medication (state type) Yes No Other Is a corset or neck brace being used? Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Physiotheraphy	Yes	No				
 Bed rest Yes Mo Medication (state type) Yes No Other Is a corset or neck brace being used? Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Manipulation	Yes	No				
 Medication (state type) Yes No Other Is a corset or neck brace being used? Yes No 8 Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Traction	Yes	No				
 Other Yes No Is a corset or neck brace being used? Yes No Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Bed rest	Yes	No				
 Is a corset or neck brace being used? Yes No 8 Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced? 	•	Medication (state type)	Yes	No				
brace being used? Please complete full details for the following questions Are your symptoms still present? How regularly are these symptoms experienced?	•	Other	Yes	No				
Are your symptoms still present?How regularly are these symptoms experienced?	•		Yes	No				
How regularly are these symptoms experienced?	8	8 Please complete full details for the following questions						
	•	Are your symptoms still present?						
 Is any further treatment being considered? 	•	How regularly are these symptoms experienced?						
	•							
9 State the date on which you last experienced these symptoms	9							

activities?	allment limit the extent of your work or leisure activities, for a	example, the pract	ising of your profession or carrying out ai	ny otner
Yes	No			
If it does, to who	at degree are business and physical activities affected?			
Has any modific back ailment, fo	cation been made at your workplace as a result of your or example, an adjustment to your desk?	Yes	No	
12 Has a disability (claim and/or a third party claim been submitted?	Yes	No	
If you have answ	wered 'Yes', please state the date of submission.			
13 Please provide	us with the name and address details of doctors administer	ring treament.		
Declaration by Life				
declare that the o Contract of Insurar	above information is true, complete and precise, and I agr nce.	ee that, together w	ith the Proposal of Insurance, it shall forn	n the basis of the
Signaturo				
Signature				
Date				

If you require any further details, please ask your financial adviser.

Alternatively you can contact your nearest Unilife office, details of which are available on our website, or get in touch using our email address: administration@unihealthandlife.com