

Personal wellbeing questionnaire

(by insured life)

Policy number

Member number*

Group number* (*Fill in for FundsAtWork)

1: Details of insured life

Name of insured life

Permanent identity/passport number

Date of birth

Financial adviser's name

Broker house code

Permanent identity number

Yes

No

Telephone

Financial adviser code

Telephone

2: General questions

1. Have you ever been diagnosed with, received treatment/medication or sought medical advice for any of the following?

	Date of diagnosis	Date of last symptoms	Date of last treatment
Stress/Anxiety/Panic disorder	<div></div>	<div></div>	<div></div>
Eating disorder	<div></div>	<div></div>	<div></div>
Depression	<div></div>	<div></div>	<div></div>
Obsessive compulsive disorder (OCD)	<div></div>	<div></div>	<div></div>
Bipolar disorder	<div></div>	<div></div>	<div></div>
Schizophrenia	<div></div>	<div></div>	<div></div>
Post-traumatic stress disorder	<div></div>	<div></div>	<div></div>
Work stress	<div></div>	<div></div>	<div></div>
Attention deficit disorder (ADD)/Attention deficit hyperactivity disorder (ADHD)	<div></div>	<div></div>	<div></div>
Alcohol and drug misuse	<div></div>	<div></div>	<div></div>
Other	<div></div>	<div></div>	<div></div>

If "other", provide full details:

2a. What were the symptoms?

	Yes	No	Date of last symptoms
Weight loss	<div></div>	<div></div>	<div></div>
Joint and muscle pains/discomfort	<div></div>	<div></div>	<div></div>
Anxiety	<div></div>	<div></div>	<div></div>
Rapid pulse	<div></div>	<div></div>	<div></div>
Loss of appetite	<div></div>	<div></div>	<div></div>
Chronic headaches/migraine	<div></div>	<div></div>	<div></div>
Worry	<div></div>	<div></div>	<div></div>
Insomnia	<div></div>	<div></div>	<div></div>
Chronic fatigue	<div></div>	<div></div>	<div></div>
Stomach trouble	<div></div>	<div></div>	<div></div>
Other	<div></div>	<div></div>	<div></div>

If "other", provide full details:

2: General questions (continued)

3. In your opinion, what caused the condition and/or relapses?

4. What was the final diagnosis your attending doctor made? Provide the date the diagnosis was made:

5. Are you currently seeing a general practitioner/counsellor/clinical psychologist or psychiatrist for your condition?

Yes ☐ No ☐

6. Are you taking any medication currently? Provide dosage of medication and type of other treatments like ECT's (Electric Shock Therapy) and psychotherapy with dates, if applicable.

Yes ☐ No ☐

Type of medication and/or treatment Dosage Date

Type of medication and/or treatment Dosage Date

Type of medication and/or treatment Dosage Date

7. Did you take any medication in the past? Provide dosage of medication and type of other treatments like ECT's (Electric Shock Therapy) and psychotherapy with dates, if applicable.

Yes ☐ No ☐

Type of medication and/or treatment Dosage Date

Type of medication and/or treatment Dosage Date

Type of medication and/or treatment Dosage Date

8. Have you ever been hospitalised for this condition?

Yes ☐ No ☐

If "yes", provide full details, including dates and reason:

9. Have you ever contemplated or attempted taking your own life?

Yes ☐ No ☐

If "yes", provide full details, including dates:

10. Have you ever received electro-convulsive therapy for this condition?

Yes ☐ No ☐

If "yes", provide full details, including dates:

11. Have you ever had any psychotherapy or counselling for this condition?

Yes ☐ No ☐

If "yes", provide full details, including dates:

12. Have you ever been absent from work as a result of your condition?

Yes ☐ No ☐

If "yes", for how long?

13. Are you completely cured and have you fully recovered?

Yes ☐ No ☐

If "no", provide full details:

14. Provide contact details of all doctors and/or alternative medical practitioners who have treated your condition. Include consultation dates:

Name

Postal address

Postal code

Date

Name

Postal address

Postal code

Date

Name

Postal address

Postal code

Date

3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

Signature of insured life

Date

D

D

M

M

Y

Y

Y

Y

No payment for the completion of this form.