

Health confirmation

(This questionnaire must be completed by the insured life)

Policy number

Member number*

Group number* (*Fill in for FundsAtWork)

The law requires you to provide all relevant information so that we can make an informed decision about what policy and cover to offer you.

It is really important that you tell us as much as you can about your health, including planned future medical procedures and consultations. Not disclosing all information puts your family at risk, since your claim pay-out may be forfeited.

1: Declaration by the insured life

I declare that I will complete the information to the best of my ability. I understand and agree that this statement forms part of the basis of the proposed contract.

Name of insured life

Permanent identity/passport number Permanent identity number Yes No

Signed at

Signature of insured life **Date**

Signature of medical professional **Date**

2: Details of medical doctor

Medical doctor's name

Practice location

Suburb City

3: About you

If you're wondering whether to tell us about a medical condition, please do.

1. Has a doctor ever told you that you have any of the following conditions? (You can select more than one answer)

- Heart attack
- Stroke
- Sugar in urine
- Diabetes
- None of these apply to me

2. In the last year, have you consulted a professional for any of the following? (You can select more than one answer)

- Stress
- Anxiety
- Depression
- Difficulty sleeping
- None of these apply to me

3: About you (continued)

3. What medication do you take on a regular basis (over-the-counter and prescription)? If you can't recall the name of the medication, tell us what you are taking the medication for.

Do not list medication taken for:

- Colds and flu from which you've fully recovered
- Food poisoning, stomach bug or upset tummy if there was no further hospital investigation and you have fully recovered
- Hay fever and once-off chest infections from which you've fully recovered
- Contraception
- Vitamins

4. In the past month, have you experienced pain on a regular basis?

Yes

No

5. Where do you feel the pain?

6. How bad is your pain, on a scale of one to ten?

No pain 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

7. What do you do for pain relief?

8. In the past 12 months, have you suffered from the following?

Back and neck problems (including muscle spasms)

Yes

No

Knees, hips and shoulder problems

Only if they've kept you off work for a week or more

Yes

No

Ankles, wrists, elbow problems

Only if they've kept you off work for a week or more

Yes

No

9. When last did you smoke (including cigarettes, cigars, pipe, vapor or other products)?

- This week
- Past 6 months
- 6 to 12 months ago
- One to 5 years ago
- More than 5 years ago
- Never smoked

3: About you (continued)

10. Is there anything else you would like to tell us about your health? Rather give us all the information because we are best able to assess if it will affect your policy or not.

11. Waist size (in cm)

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 (Note: Measurements to be taken by nurse)
12. Height (without shoes, in cm)

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 (Note: Measurements to be taken by nurse)
13. Weight (with clothes, in kg)

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 (Note: Measurements to be taken by nurse)
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