

## Arthritis questionnaire

(by insured life)

Policy number

Member number\*

Group number\* (\*Fill in for FundsAtWork)

### 1: Details of insured life

Name of insured life	<input type="text"/>											
Permanent identity/passport number	<input type="text"/>						Permanent identity number	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Date of birth	<input type="text"/>	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Financial adviser's name	<input type="text"/>						Financial adviser code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Broker house code	<input type="text"/>						Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 2: General questions

- When did you first have symptoms?
- When did you last have symptoms?
- When were you first diagnosed with arthritis?
- When did you last receive treatment for arthritis?
- What type of arthritis do you have?
 

Rheumatoid arthritis <input type="checkbox"/>	Osteoarthritis <input type="checkbox"/>	Psoriatic arthritis <input type="checkbox"/>	Gouty arthritis <input type="checkbox"/>
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6. Which joints were or are affected?  
(Indicate left or right side)

Hands and wrists <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Elbows <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Shoulder <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>
Spine <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Hips <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Knees <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>
Ankles <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Feet <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>	Other <input type="checkbox"/>	L <input type="checkbox"/>	R <input type="checkbox"/>

If "other", provide full details:

7. Indicate the symptoms, characteristics and complications of your arthritis:

Pain and swelling <input type="checkbox"/>	Inflammation <input type="checkbox"/>	Fatigue <input type="checkbox"/>
Immobility <input type="checkbox"/>	Restricted movement <input type="checkbox"/>	Fever <input type="checkbox"/>
Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
Daily <input type="checkbox"/>	Monthly <input type="checkbox"/>	Annually <input type="checkbox"/>
Constant <input type="checkbox"/>	Relapsing and remitting <input type="checkbox"/>	Back pain <input type="checkbox"/>
Depression <input type="checkbox"/>	Lack of sleep <input type="checkbox"/>	Other <input type="checkbox"/>

If "other", provide full details:

8. What treatment and investigations did you receive or are you receiving for your arthritis?

Surgery <input type="checkbox"/>	Arthroscopy <input type="checkbox"/>	Medication <input type="checkbox"/>
Physiotherapy <input type="checkbox"/>	X-rays <input type="checkbox"/>	CT/MRI scans <input type="checkbox"/>
Gold <input type="checkbox"/>	Methotrexate <input type="checkbox"/>	Cortisone <input type="checkbox"/>

9. Have you consulted any of the following professionals in connection with your arthritis?

Rheumatologist <input type="checkbox"/>	Orthopaedic surgeon <input type="checkbox"/>	Physiotherapist <input type="checkbox"/>
Specialist physician <input type="checkbox"/>	General practitioner <input type="checkbox"/>	Other <input type="checkbox"/>

If "other", provide full details:

## 2: General questions (continued)

10. Has your ability to perform your occupation, sport or activities of daily living (bathing, walking, eating and cleaning) been affected?  Yes  No
- If "yes", provide full details:
11. Have you ever been hospitalised for this condition?  Yes  No
- If "yes", provide full details, including dates and duration of hospitalisation:
12. Provide the names of all the doctors and medical practitioners you have consulted regarding this condition:
- Name
- Postal address
- Postal code
- Name
- Postal address
- Postal code
- Name
- Postal address
- Postal code
13. Has any other body system (heart, lungs, liver, skin, etc.) been affected by your arthritis?  Yes  No
- If "yes", provide full details:
14. Have you been investigated for any other connective tissue disorders (e.g. systemic lupus, erythematosus, fibromyalgia, scleroderma, etc.)?  Yes  No
- If "yes", provide full details:
15. Provide any additional information relevant to this condition:

## 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