

Joint 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"/>
Financial adviser's name	<input type="text"/>		
Broker house code	<input type="text"/>	Financial adviser code	<input type="text"/>
		Telephone	<input type="text"/>

2: General questions

- When did you first have symptoms?
- When did you last have symptoms?
- When was the condition first diagnosed?
- When did you last receive treatment for the condition?
- What was the final diagnoses?

6. Which joints were or are affected? *(Indicate left or right side)*

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

If "other", specify:

7. What was the cause of the condition?

Accident or injury	<input type="checkbox"/>	Degenerative disease	<input type="checkbox"/>	Infection	<input type="checkbox"/>
Complication of another disease or disorder	<input type="checkbox"/>	Other	<input type="checkbox"/>		<input type="checkbox"/>

Provide full details:

8. Describe the symptoms, characteristics and complications of this condition:

Pain and swelling	<input type="checkbox"/>	Inflammation	<input type="checkbox"/>	Restricted movement	<input type="checkbox"/>
Calcification	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	Fracture	<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"/>
Osteoarthritis	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Other	<input type="checkbox"/>

If "other", specify:

2: General questions (continued)

9. What treatment and investigations did you receive, or are you receiving for this condition?

Surgery		Arthroscopy		Medication	
Physiotherapy		X-rays		CT/MRI scans	

Provide full details:

10. Has your ability to perform your occupation, sport or activities of daily living (bathing, walking, eating and cleaning) been affected?

Yes		No	
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If "yes", provide full details:

11. Have you ever been hospitalised for this condition?

Yes		No	
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If "yes", provide full details, including dates and duration of hospitalisation:

12. Provide the names of all the doctors and medical practitioners consulted regarding this condition:

Surname		Initials				
Surname		Initials				
Surname		Initials				
Surname		Initials				

13. 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

D	D	M	M	Y	Y	Y	Y
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