

Chest pain 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 felt pain or discomfort in the chest? If Yes, did the pain or discomfort involve any of the following:

Yes

No

The left shoulder, arm or hand

The neck or jaw

Both shoulders

The middle of the chest

The left side of the chest

Other

If "other", provide full details:

2. Was the nature of the pain or discomfort:

Pressure or constriction

A stabbing pain

A burning feeling

A sharp pain

An ulcer

Other

If "other", provide full details:

3. Was the pain or discomfort brought on by any of the following?

Exercise

Excitement

Exertion

Strain or stress

Other

If "other", provide full details:

4. Did the pain or discomfort occur at rest?

Yes

No

If "yes", indicate when it occurred:

During the night

After eating

Other

If "other", provide full details:

5. When was the first attack?

When was the last attack?

What was the average duration of the pain or discomfort? min

How frequently do these attacks occur?

6. During or after experiencing the pain or discomfort, did you:

Consult your doctor

Have emergency treatment

Go to hospital

See a specialist

Other

If "other", provide full details:

UNDERW0270622E | Chest pain questionnaire (by insured life)

1 / 2

7. Have you ever been prescribed medication for the pain or discomfort?		Yes	No
If "yes", provide the following information:			
Type of medication			
Dosage		Date used	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of medication			
Dosage		Date used	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of medication			
Dosage		Date used	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8. Was the diagnosis made by the doctor?			
		Yes	No
If "yes", was it any of the following:			
Muscular/Skeletal problem		Heart attack	
Respiratory problem		Other	
Angina			
Stomach complaint			
If "other", provide full details:			
9. How much physical activity are you allowed?			
		Full activity	Restricted activity
If restricted, please provide date when you may resume full activity			
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
10. Has an electrocardiogram (ECG) or a chest X-ray ever been taken?			
		Yes	No
If "yes", provide date of the most recent test			
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
11. Provide any further relevant details, including the name(s) and address(es) of the doctors/specialists and/or cardiologists who attended to you:			
Name of medical doctor			
Postal address			
		Postal code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of medical doctor			
Postal address			
		Postal code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of medical doctor			
Postal address			
		Postal code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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.

No payment for the completion of this questionnaire.