

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

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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Eating disorder	<input type="text"/>	<input type="text"/>	<input type="text"/>
Depression	<input type="text"/>	<input type="text"/>	<input type="text"/>
Obsessive compulsive disorder (OCD)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bipolar disorder	<input type="text"/>	<input type="text"/>	<input type="text"/>
Schizophrenia	<input type="text"/>	<input type="text"/>	<input type="text"/>
Post-traumatic stress disorder	<input type="text"/>	<input type="text"/>	<input type="text"/>
Work stress	<input type="text"/>	<input type="text"/>	<input type="text"/>
Attention deficit disorder (ADD)/Attention deficit hyperactivity disorder (ADHD)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Alcohol and drug misuse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>

If "other", provide full details:

2a. What were the symptoms?

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

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
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No payment for the completion of this form.

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