

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

2: General questions

1a. When did your first symptoms occur?

1b. When did you last have symptoms?

2. Describe the nature of your symptoms and the exact location of your discomfort.

3. How often do these symptoms occur and how long do they last?

4. Did or does the discomfort spread to other parts of the abdomen or back and/or the chest or arms? Yes No

5. Have you ever

Vomited blood <input type="checkbox"/>	Had chronic diarrhoea <input type="checkbox"/>	Had difficulty swallowing <input type="checkbox"/>	Had anaemia <input type="checkbox"/>
Had shortness of breath <input type="checkbox"/>	Passed black stools <input type="checkbox"/>	Had tightness of the chest <input type="checkbox"/>	

6. Have you lost weight in the past year? Yes No
If "yes", provide full details:

7. Do you experience a decreased appetite? Yes No
If "yes", provide full details:

8. Have you experienced any recent change in your usual bowel habits? Yes No
If "yes", provide full details:

9. Have you ever had any examination of the gastro-intestinal tract or gall bladder (i.e. barium meal/enema, gastroscopy, colonoscopy, ultrasound of the abdomen)? Yes No
If "yes", provide full details:

10. Provide full details of any treatment received and specify whether diet, medical, surgical or all three.

11. Are you currently receiving any treatment? Yes No
If "yes", provide full details, including the brand name of any medication, the dosage and name and address of your medical doctor.

12. What was the final diagnosis? (If an ulcer, state whether gastric, duodenal or pyloric.)

13. Have you ever had an electrocardiogram (ECG)? Yes No
If "yes", provide the date and name of your medical doctor.

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.