

To be completed by the Life to be Insured

Given Name(s)	<input type="text"/>	Date of Birth	<input type="text" value="DDMMYYYY"/>
Family Name	<input type="text"/>	Quotation Number	<input type="text"/>

Full and Complete Disclosure

Please complete this form to supplement the answers you have given in your application. Once completed, this questionnaire will form part of your application. Every question we ask is relevant and important and must be answered. If this form is incomplete or does not address each question, it could result in delays.

Personal Data

All personal data collected in this form will be treated as strictly Private and Confidential in line with our [Data Protection Policy](#) and our [Website Privacy Policy](#). These policies can be viewed at www.unisuregroup.com

Your insurance adviser or broker is an Intermediary appointed by Unisure Limited to act on your behalf to assist you with any administration which may be required in the processing of your application. The Intermediary and its authorised employees will therefore have access to and knowledge of the personal data in this form.

Guardrisk Life International Limited and Unisure Limited may pass this personal data, and any medical information provided, to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors, and to any company or agency appointed for these purposes to allow for the proper administration of your application and your policy.

In some limited circumstances, Guardrisk Life International Limited and Unisure Limited may be legally required to share certain personal data, which might include yours, if we are involved in legal proceedings or complying with legal obligations, a court order, or the instructions of a government authority.

A - Drug Use

1. Please indicate which of the following non-prescription drugs you have used in the last 7 years.

Other than legally prescribed as treatment for a medical condition and under the supervision of your doctor.

i. Amphetamines (speed, uppers, crystal meth, ice, appetite suppressants, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ii. Anabolic Steroids	<input type="checkbox"/> YES	<input type="checkbox"/> NO
iii. Barbiturates (amytal, phenobarbital etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
iv. Cannabis (marijuana, dope, grass, pot, hashish, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
v. Cocaine (blow, coke, crack, snow, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
vi. Ecstasy (methamphetamine, MDMA, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
vii. Opiates (codeine, heroin, methadone, morphine, pethidine, smack, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
viii. Psychedelics (magic mushrooms, LSD, acid, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ix. Sedatives (diazepam, downers, nitrazepam, tranquilisers, sleeping pills, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
x. Solvents (glue, aerosol, thinners, nitrous oxide, petrol, etc)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
xi. Others	<input type="text"/>	

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2. If you answered "Yes" for any of the above, please provide further details, as follows:

Drug Used	Date First Used	Date Last Used	Frequency of Use

3. Have you ever used drugs intravenously?

☐

YES

☐

NO

B - Alcohol Use

1. Please provide details of your average weekly alcohol consumption.

Type of Alcohol	Average Units per Week
Beer (1 unit = ½ pint / 280ml)	
Wine (1 unit = 1 small glass of wine / 100ml)	
Spirits (1 unit = 1 measure / 25 – 40ml)	

2. Do you ever drink more than the amounts listed above?

If you answered "Yes", please provide further details, including dates or occasions, in the space provided below.

3. At what age did you start regularly drinking alcohol?

4. When did you last drink alcohol?

C - General Drug and Alcohol Use Questions

1. Have you ever suffered any health problems or medical condition because of drug or alcohol use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever sought or been referred for medical advice for drug or alcohol use, or been advised to reduce or stop your alcohol consumption?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you taken part in counselling, therapy, or rehabilitation programme for drug or alcohol use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Have you ever been hospitalised or treated for a drug or alcohol overdose?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever been arrested or convicted for any drug or alcohol related offence?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you ever been ordered to attend any drug or alcohol awareness programme by a court?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Have you ever missed work because of drug or alcohol use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Have your work duties been affected in any way because of drug or alcohol use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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9. Have you ever been a member of Alcoholics Anonymous or a similar organisation?

☐ YES

☐ NO

If you answered "Yes" to Question 9, please answer the following questions:

i. When did you join?

DDMMYYYY

ii. Are you currently an active member?

☐ YES

☐ NO

iii. How often do you attend meetings?

iv. How many meetings have you attended in the last twelve months?

v. Have you had any lapses?

☐ YES

☐ NO

If you answered "Yes", please provide further details, including dates, in the space provided below.

Question Reference Number	If you answered "Yes" to any of questions 1 – 8 in Part C, please provide further details, in the space provided below. Please include dates, and other applicable details such as diagnoses, duration of any illness, the name and address of the attending physician or medical centre you attended for any medical condition. Please also advise whether you have completely recovered from any medical condition noted.

If there is insufficient space, please continue on a separate sheet, ensuring that you sign and date any additional pages.

Declaration

I declare that the information given in this form is true, complete and precise to the best of my knowledge and belief and I agree it will form part of my application and therefore the basis of the contract of insurance on my life. I understand and accept that failure to disclose a material fact or the giving of false information may give Guardrisk Life International Limited the right to cancel from inception any Policy issued and may invalidate any future claim.

I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual, organisation or government office that has any records or knowledge of me or my health to disclose such information to Guardrisk Life International Limited, or Unisure Limited. This authorisation shall irrevocably bind my successors and assignees and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

Signature of Life to be Insured:

Date:

DDMMYYYY

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