Headache **Questionnaire**

Application Reference Number

The questionnaire must be completed by the Life Insured.
Important: No compensation is payable if a Medical Examiner completes this questionnaire.

Particulars of Life Insured

First name(s)

Last name

Identity No./Passport No. (Compulsory)

Date of birth D D M M Y Y Y Y

Address

Information regarding injury, accident or condition

1. Please state as accurately as possible the date on which you first developed headaches?

D D M M Y Y Y Y

2. How frequently did the headaches occur after this date?

3. When did the headaches last occur?

4) Did you ever obtain medical advice? Yes No

If you have answered 'Yes', state how often. Please provide the name and address of the doctor(s) you consulted.

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5. Were any special examinations and/or tests carried out? Yes ☐ No ☐

If you have answered 'Yes', please provide further details.

6. Will any examinations and/or tests be carried out in the future? Yes ☐ No ☐

If you have answered 'Yes', please provide further details.

7. If medication is being prescribed now or was prescribed in the past, please give details of the name(s), dosage(s) and the frequency of use.

8. Were you at any time away from work for five days or longer as a result of headaches? Yes ☐ No ☐

If you have answered 'Yes', please provide details of the duration of the period of absence, and state the number of times you were absent.

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Signature

Date

D	D	M	M	Y	Y	Y	Y

If you require any further details, please ask your financial adviser.

Alternatively you can contact your nearest Unisure office, details of which are available on our website, or get in touch using our email address: admin.life@unisuregroup.com

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