Back Pain 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 dd/mm/yyyy

Address

Information regarding condition

1 What caused the back ailment? *(Please give a description next to the ailment.)*

- Injury ☐ Yes ☐ No
- Illness ☐ Yes ☐ No
- Congenital ☐ Yes ☐ No
- Other ☐ Yes ☐ No

2 Date of commencement of back symptoms/back pain dd/mm/yyyy

3 What was the nature of the condition? *(Please provide further details on the relevant line.)*

- Fracture of vertebrae ☐ Yes ☐ No
- Lesion of the disc ☐ Yes ☐ No
- Muscle injury ☐ Yes ☐ No
- Ligament injury ☐ Yes ☐ No
- Curvature of the spine ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Whiplash ☐ Yes ☐ No
- Other ☐ Yes ☐ No

4 Which area of the vertebral column was, or is, affected?

- Cervical (neck) vertebrae or discs between the vertebrae ☐ Yes ☐ No
- Thoracic (chest) vertebrae or discs between the vertebrae ☐ Yes ☐ No
- Lumbar (lower back) vertebrae or discs between the vertebrae ☐ Yes ☐ No
- Sacral (coccyx) vertebrae ☐ Yes ☐ No

5 Did you undergo any X-rays or MRI scans? ☐ Yes ☐ No

If 'Yes', please provide dates

6 Did the investigation reveal any abnormalities? ☐ Yes ☐ No

If you have answered 'Yes', please provide full details

7 What treatment was or is being applied? *(Please state the date and your present condition.)*

- Laminectomy ☐ Yes ☐ No
- Fusion ☐ Yes ☐ No
- Physiotheraphy ☐ Yes ☐ No
- Manipulation ☐ Yes ☐ No
- Traction ☐ Yes ☐ No
- Bed rest ☐ Yes ☐ No
- Medication (state type) ☐ Yes ☐ No
- Other ☐ Yes ☐ No
- Is a corset or neck brace being used? ☐ Yes ☐ No

8 Please complete full details for the following questions

- Are your symptoms still present?
- How regularly are these symptoms experienced?
- Is any further treatment being considered?

9 State the date on which you last experienced these symptoms dd/mm/yyyy

10 Does the back ailment limit the extent of your work or leisure activities, for example, the practising of your profession or carrying out any other activities?

☐ Yes ☐ No

If it does, to what degree are business and physical activities affected?

11 Has any modification been made at your workplace as a result of your back ailment, for example, an adjustment to your desk? ☐ Yes ☐ No

12 Has a disability claim and/or a third party claim been submitted? ☐ Yes ☐ No

If you have answered 'Yes', please state the date of submission.

13 Please provide us with the name and address details of doctors administering treament.

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 dd/mm/yyyy

UL BackPain Questionaire 12.16

If you require any further details, please ask your financial adviser.
Alternatively you can contact your nearest Unilife office, details of which are available on our website, or get in touch using our email address:
administration@unihealthandlife.com