

Application Reference Number

**The questionnaire must be completed by the Life Insured.**

Important: No compensation is payable if a Medical Examiner completes this questionnaire.

**Section 1: Particulars of Life Insured**

First Name(s)

Last Name

Identity No./Passport No.

Compulsory

Date of birth

dd/mm/yyyy

Address

  
  


Please supply full and accurate details in connection with:

1. When did the symptoms first begin?

2. What is the duration of the symptoms?

3. How frequent are the symptoms?

4. When did you last have symptoms?

5. Please describe the symptoms:

(a) Describe fully the episodes:

(b) Have you been absent from work?

 Yes  No

(c) Have you been hospitalised?

 Yes  No

If 'Yes', please give full details including dates and duration

  
  


6. Are the symptoms/episodes caused by any special circumstances or conditions?

 Yes  No

If 'Yes', please give full details

7. Have you consulted a doctor for this condition?

Yes

No

If 'Yes', please provide name, address and date of last consultation


8. What treatment or drugs have you taken to relieve the symptoms?  
Give full details of treatment or dosage


9. When did you last receive medication/treatment?

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10. Is there any likelihood of surgical or any other treatment in the future?

Yes

No

If 'Yes', please give full details


**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

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Date

	dd/mm/yyyy
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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