NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

MEDICAL DISORDER QUESTIONNAIRE

Reference: _____

1. **Date the symptoms first appeared:** _____/_____/_____ (D M Y)

2. **Please provide a brief description of the symptoms felt:** _____

3. **Date(s), name(s) and address(es) of the physician(s) consulted:** _____

4. **Diagnosis:** _____

5. **Any diagnostic tests done and results**
   Test: _____ Date: _____ Result: _____
   Test: _____ Date: _____ Result: _____
   Test: _____ Date: _____ Result: _____
   Test: _____ Date: _____ Result: _____

6. **Were any treatments prescribed? Provide the complete details:** _____

7. **Prescriptions:** _____

8. **Did you undergo any surgery? Provide the complete details:** _____

   Date: _____/_____/_____ (D M Y) Location : _____

9. **Have you missed any time off work?** ❒ Yes ❒ No **If yes**, provide the complete details:

   From: ____/____/____ (D M Y) To: ____/____/____ (D M Y) If more than once: From: ____/____/____ (D M Y) To: ____/____/____ (D M Y)

10. **Have you fully and completely recovered?** ❒ Yes ❒ No
    If no, provide the complete details: _____

11. **Do you have any or permanent sequel or side effects?** ❒ Yes ❒ No
    If yes, please provide the complete details: _____

12. **Do you foresee any further or additional consultations? Provide details:** _____

I declare the information above is true and complete and that it will form part of my insurance application with **UL Mutual**.

X_____ **SIGNATURE OF THE PROPOSED INSURED**

X_____ **SIGNATURE OF THE POLICY OWNER**

X_____ **WITNESS**

_____ **DATE**