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

GASTROINTESTINAL DISORDER QUESTIONNAIRE

1. **Date of the first symptoms:** _____
2. **Frequency of attacks (or pain):** _____
3. **Date of the last symptoms:** _____
4. **Did the symptoms have anything to do with your diet?** _____
5. **Symptoms:**
   - ☐ Vomiting
   - ☐ Black stools
   - ☐ Others: _____
   - ☐ Pain decreased after eating
   - ☐ Pain after eating
6. **Have you lost weight in the last 6 months?** Yes ☐ No ☐ **If yes**, how much: _____
7. **What was your physician's diagnosis?** _____

   _____
8. **Have you ever had any special examination undertaken?** Yes ☐ No ☐

   If yes, provide date, location and results: _____
9. **Have you ever undergone surgery as a result of a gastrointestinal disorder?** Yes ☐ No ☐

   If yes, provide complete details: _____
10. **If you have had a surgery, do you still feel any symptoms?** Yes ☐ No ☐

    If yes, provide complete details: _____
11. **Do you currently follow a diet?** Yes ☐ No ☐
12. **Are you currently under treatment?** Yes ☐ No ☐

    If yes, provide complete details: _____
13. **Name and address of the attending physician:** _____

    _____
14. **Date of the last consultation:** _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____

SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____

WITNESS **DATE**