

# Supplementary health statement

Application number:

Person to be Insured:

1) Please advise the name of the condition.

  


2) The cause.

  


3) Please advise:

(a) Date symptoms commenced?

 /  / 

(b) Describe your symptoms.

(c) How often do/did you have symptoms?

(d) Are you now totally symptom free?

 Yes  No

If 'yes', how long have you been free of any symptoms?

4) Have you ever been off work or your normal daily activities restricted in any way related to this condition?

 Yes  No

If 'yes', please provide details:

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		
/ /		

5) Have you any residual, on-going effects or restriction in your daily activities?

 Yes  No

If 'yes', please advise date(s), type and result(s).

  
  


6) Have you taken regular or occasional medication for this condition?

 Yes  No

If 'yes', please advise names of medication(s), dosage(s) and frequency.

  


Are you still taking this medication?

 Yes  No

If 'no', please advise date ceased.

 /  /

- 7) Have you had any other treatment for this condition, eg. physiotherapy, operation, alternative remedies?  Yes  No  
If 'yes', please advise date, type of treatment and tests.
- 8) Have you had any diagnostic investigations, eg. scope, scan, x-rays, EEG etc  Yes  No  
If 'yes', please advise date, type of test and result.
- 9) Have you ever been in hospital or received emergency treatment for anything related to this condition?  Yes  No  
If 'yes', please advise date, type of treatment and name of hospital.
- 10) Please provide details of your most recent visit to a doctor or other therapist for anything related to this condition. Include date, reason for consultation, investigations, findings and advice.
- 11) Has further treatment been recommended for this condition?  Yes  No  
If 'yes', please provide details.
- 12) Does your usual doctor have details of this condition?  Yes  No  
If 'no', please provide name and address of doctor who has full details.
- 13) Since the date of your application have you suffered from any sickness or injury or had any reason to receive medical attention or advice?  Yes  No  
If 'yes', please provide details.

## Your duty of disclosure (to be completed in all cases)

Please read carefully.

- 1) This questionnaire will form part of the application and together with the application, (declaration and any personal statement or telephone interview) shall be the basis of the proposed insurance contract.
- 2) The person insured and the policy owner must tell Asteron Life of any change in circumstances that is material to this application. This duty continues until the application is accepted and a policy document has been issued. This is important even if you have separately discussed something with your adviser. The duty of disclosure also applies if in future there is a request to extend or alter the policy, or application to reinstate the policy after it has lapsed.
- 3) If the information provided to us is incomplete or incorrect in any material way, then we may decline the application or it may affect the ability to claim in future. If this happens, we may reduce claim benefits or decide not to accept a claim. We may also exercise any legal rights we have to cancel or avoid the policy from inception. Premiums paid may be forfeited and any claims already paid may have to be paid back.

I declare that the answers given above are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application. I have read and understood the duty of disclosure described above, and acknowledge it is my responsibility to ensure I have provided all material information whether that information has been specifically requested or not.

Signature of the Person to be Insured  Date  /  /