

# Arthritis and gout

## Supplementary questionnaire (to be completed by the insured person)

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### Instructions

Please complete this form to supplement the answers you have given on your proposal. The information you give may assist us in the assessment of your proposal and help minimise the need for medical reports.

Please complete this form in **CAPITAL** letters. All questions must be answered accurately with full disclosure of all relevant information. If there is insufficient space for any answer, please continue on a separate piece of paper and attach to this questionnaire.

### 1 Personal details

#### Full name of the insured person

Title  Mr  Mrs  Miss  Ms  Dr  Other (please give details)

Family name

Forename(s)

Date of birth

Proposal number

### 2 Supplementary questions

Please indicate which type of arthritis (e.g. rheumatoid, osteoarthritis) or gout you suffer from.

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Please state the date that your gout or arthritis was diagnosed.

Date

Please provide details and dates of any treatment you are currently receiving.

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Please provide details and dates of any treatment you have received in the past (e.g. Brufen, Indocid).

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Please provide names and addresses of all doctors you have consulted for this condition.

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## Supplementary questions (continued)

Have you ever been treated with steroids? (e.g. Prednesol, Betnesol), Antirheumatic drugs (eg gold, azathioprine, sulphasalazine, methotrexate etc) or anti-TNF agents (eg etanercept, infliximab, rituximab etc).

Yes  No

If yes, please give details of drug and dates.

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Has the gout or arthritis restricted you from carrying out your day-to-day activities (especially your occupation)?

Yes  No

If 'Yes', please state how.

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Has any surgery been undertaken or is any surgery planned?

Yes  No

If 'Yes', please provide details plus date(s).

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If you suffer from gout, please advise when your Uric Acid level was last measured and the result of the test.

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When did you last have symptoms?

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How frequently do your symptoms recur?

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Do you require a walking stick or any other mobility aid?

Yes  No

How severe/restrictive are your symptoms?

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Have you at any time been off work with your condition?

Yes  No

If 'Yes', please state dates and duration.

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Have you at any time been off work as a result of your condition?

Yes  No

If 'Yes', please state dates and duration.

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Do you drink alcohol?

Yes  No

If 'Yes', please state the number of units consumed.

units per week

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Note: 'social' or 'occasional' are not acceptable answers.  
(1 unit = single measure of spirits or one 125ml glass of wine or 250ml beer).

Have you ever habitually drunk more in the past?

Yes  No

If 'Yes', please give details.

units per week

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Please provide us with any additional information about your condition that will help us assess your proposal (e.g. dates, names and addresses of doctors/hospitals/clinics).

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**Thank you for completing this form. Please return it to us in a sealed envelope.**

### 3 Privacy notice

The personal information requested in this form is collected and used by Zurich International Life Limited (the Company) as Data Controller in line with the Data Protection Policy. Full details can be found online at <https://www.zurichinternational.com/en/zurich-international-life/about-us/privacy> or contact us for a copy.

I declare that the answers given, whether in my handwriting or not, are true and complete to the best of my knowledge and belief. I agree that this form will constitute part of my proposal and that failure to disclose any material fact known to me may constitute grounds for rejection of a claim or repudiation of the contract.

### 4 Declaration/consent

#### Special category data consent

By signing this form, I consent to the Company processing my medical and health information and authorise the seeking and processing of information from any medical practitioner who has attended me or from any insurer to which an application has been made for insurance. I confirm such authorisation shall remain in force after my death.

#### Withdrawal of consent

I understand that where I have provided consent I have the right to withdraw the consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.

**If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.**

Signature of life to be insured

Date

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