

Back disorder

Supplementary questionnaire (to be completed by the life to be insured)

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

When did your back disorder occur?

Date

Please provide details below of the exact diagnosis.

Please provide details of the frequency and severity of symptoms and the duration(s) of incapacity including dates and time off work.

How has the condition been treated. (i.e. painkillers, physiotherapy, operation, etc.)

Is future surgery being considered or planned?

Yes No

If 'Yes', please give details below.

Is there any ongoing treatment with pain killers or physiotherapy?

Yes No

If 'Yes', please give details below.

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Registered office: Zurich House, Isle of Man Business Park, Douglas, Isle of Man, IM2 2QZ, British Isles.
Telephone +44 1624 662266 Telefax +44 662038

Hong Kong office: 25-26/F, One Island East, 18 Westlands Road, Island East, Hong Kong.
Telephone +852 3405 7150 Telefax +852 3405 7268 www.zurich.com.hk

Zurich International Life Limited acting through its Singapore branch at Singapore Land Tower #29-05, 50 Raffles Place, Singapore 048623. Telephone +65 6876 6750 Telefax +65 6876 6751.

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