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# Growths/Cysts/Tumours/Lumps 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

Policy number (if known)

**Full name of life to be insured**

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

Family name

Forename(s)

Date of birth D D M M Y Y Y Y

### 2 Supplementary questions

When were you first aware of the growth or swelling? Date D D M M Y Y Y Y

Where precisely was it?

Do you know the initial diagnosis or what it was called? ☐ Yes ☐ No

Please provide details in the box below.

Is it still there? ☐ Yes ☐ No

If 'Yes', what investigations have been carried out? Please detail the dates and results of the tests undertaken.

Please give details of the follow-up/treatment/surgery that has been proposed.

## Supplementary questions (continued)

Please provide the name and address of all doctors you have consulted for this condition.

Has it been removed? ☐ Yes ☐ No If 'Yes', when? Date D D M M Y Y Y Y

By whom and where (e.g. doctor/surgeon/hospital, please also provide names and addresses)?

How (e.g. local or general anaesthetic, cryotherapy or other methods)?

What treatment did you have following its removal (e.g. tablets, radiotherapy, chemotherapy)?

What treatment (if any) are you still receiving (e.g. tablets, chemotherapy, radiotherapy)?

How was your condition diagnosed? ☐ Benign ☐ Malignant

For how long was your condition monitored/followed up and how often?

How often will you be reviewed or monitored in the future?

Have you had any recurrences of this condition? ☐ Yes ☐ No

If 'Yes', please provide details below.

Have you lost significant time e.g. weeks, off work? ☐ Yes ☐ No

If 'Yes', please detail the dates and duration of these absences from work.

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).

If you have any hospital papers such as histology reports, please send copies to us with this form.

**Thank you for completing this form. Please return it to us with your proposal, or if you prefer, 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.

## 4 Declaration/consent

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.

### 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.

Signature of life to be insured

Date D D M M Y Y Y Y





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