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SPECIAL PERSONAL QUESTIONNAIRE

INDIVIDUAL POLICY ☐ CORPORATE SCHEME ☐

THIS QUESTIONNARE WILL FORM PART OF APPLICATION NO: _____ Date D D M M Y Y Y Y

ON THE LIFE OF: _____ ID No. _____

Contact Details Home No. (C O D E) _____ Work No. (C O D E) _____

Fax No. (C O D E) _____ Mobile No. _____

Email Address _____

Postal Address of owner _____

_____ Code C O D E

Please supply accurate and full details in connection with: _____

_____

1. How long did they last? _____
2. What was the cause of reason? _____
3. On what date did the symptoms first occur? _____
4. Describe the symptoms you had? _____
5. How severe were they? _____
6. How frequently did they occur? (daily, weekly, etc) _____
7. Were you examined or treated at any hospital or Institution? ☐ YES ☐ NO

If "YES", please

(a) Name of hospital or institution _____

(b) Whether you were admitted as a private, free or a departmental patient _____

(c) Your hospital or institution reference number _____

8. Names and addresses of doctors consulted. _____

_____

9. What investigations were done or advised? _____
10. What was your final diagnosis? _____
11. What treatment was advised or given? _____
12. When did you last receive treatment and what was the response to this treatment? _____
13. When did you last have symptoms? _____
14. Is there any likelihood or surgical or other treatment in the future? ☐ YES ☐ NO

I hereby declare that the above particulars and answers are complete and true.

Dated at _____ this _____ day of _____

_____
SIGNATURE OF APPLICANT

Please note that in the event of any modification of this standard form Resolution Life will regard this form as being invalid and of no force and effect.
Do not sign blank or incomplete forms.