CHOLESTEROL QUESTIONNAIRE – APPLICANT

(This questionnaire will form part of the application)

First Name:		**Last Name:**	
Date of Birth (mm/dd/yyyy):		**Policy/Application No.:**	

1. When were you first diagnosed with raised cholesterol?

2. What was your most recent Total Cholesterol or Cholesterol/HDL Ratio reading within the last six (6) months?

Date Test Was Done (Month/Year)	Results	
	Total Cholesterol	Cholesterol/HDL Ratio
	_____ ☐ mmol/L _____ ☐ mg/dL	

3. Are you currently on medication for this condition?

☐ Yes (Please provide details below.) ☐ No, it was never prescribed

Name of Medication	Date Prescribed (Month/Year)	Frequency and Dosage	Date Medication Stopped (Month/Year)	Reason

4. Has your medication been increased (change of medication, dosage and frequency) by your attending physician?

☐ Yes (Please provide details below.) ☐ No

5. Were you prescribed medication but has stopped taking it?

☐ Yes (Please provide details below.)	☐ My attending physician asked me to stop my medication; only regular follow-up is needed.
☐ No	☐ It was my own personal decision and without my attending physician's advice.

6. Have you been told that you have familial hypercholesterolemia? ☐ Yes ☐ No

7. Please provide any additional information that you feel is important.

8. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of Doctor, Hospital or Clinic	Address	Date of Last Consultation (Month/Year)

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.

Name:	
Signature:	
Date of Signing:	