

**CYST, LUMP, MASS AND TUMOR QUESTIONNAIRE –**

**APPLICANT**

(This questionnaire will form part of the application)

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

|  |  |
| --- | --- |
| 1. When was the cyst, lump, mass or tumor discovered?
 |       |
| 1. Where is the exact location of the cyst, lump, mass or tumor?
 |
|       |
| 3. What other tests or investigations have you undergone for this condition? |
| Name of Test or Investigation | Date (Month/Year) | Results |
|       |       |       |
|       |       |       |
|       |       |       |
| 1. Has the cyst, lump, mass or tumor been removed?
 | [ ]  Yes (Please provide details.) [ ]  No |
|       |
| Diagnosis | Date of Removal (Month/Year) | Histopathology/Biopsy Result (Please attach a copy of the report) |
|       |       |       |
|       |       |       |
| 1. Did you undergo chemotherapy?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Start Date | Date of Last Cycle (Month/Year) | Total Number of Cycles |
|       |       |       |
| 1. Did you undergo radiation treatment?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Type | Start Date (Month/Year) | Total Number of Cycles |
| [ ]  External Radiation |       |       |
| [ ]  Internal Radiation |       |       |
| [ ]  Systemic Radiation |       |       |
| 7. Were you prescribed medication for this condition? |
| Name of Medication | Date Prescribed (Month/Year) | Dosage | Date Medication Stopped (Month/Year) | Reason |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| 1. Were you required to come back for a follow-up check-up?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Frequency | Date of Last Consultation (Month/Year) | Results |
|       |       |       |
| 1. Has there been any recurrence?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Date (Month/Year) | Site/Location | Treatment |
|       |       |       |
| 1. Please provide any additional information that you feel is important.
 |
|       |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition:
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| Name of Doctor, Hospital or Clinic | Address | Date of Last Consultation (Month/Year) |
|       |       |       |
|       |       |       |

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| **DECLARATION** |
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| **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:** |       |

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| --- | --- |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Date of Signing:** |       |

