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

**APPLICANT**

(This questionnaire will form part of the application)

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | |
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|  | | | |  | | | | | | | | | |  | | |
| 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) | | | | | |
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| 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 |
|  |  | | | | |  | | | |  | | | | | |  |
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| 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: | | | | | | | | | | | | | | | | |
| 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.** |

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| --- | --- |
| **Name:** |  |

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

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

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