**DIGESTIVE DISORDER**

**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.:** |       |

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| 1. Please state the precise diagnosis, or nature of the condition. Attach a copy of any medical report if available.
 |
| [ ]  GERD | [ ]  Liver Enlargement | [ ]  Others:       |
| [ ]  Hiatal Hernia | [ ]  Gallstones |
| [ ]  Duodenal Ulcer | [ ]  Barrett’s Esophagus |
| [ ]  Ulcerative Colitis | [ ]  Crohn’s Disease |
| [ ]  Irritable Bowel Syndrome | [ ]  Diverticulitis |
| 1. Were you prescribed any medication for this condition?
 |       |
| 1. Please describe your symptoms.
 |
|       |
| 1. What causes or triggers your attacks?
 |
|       |
| 1. How often do you usually suffer attacks?
 |
|       |
| 1. Do you still experience symptoms?
 | [ ]  Yes [ ]  No |
| If no, when did you last experience symptoms or last time you had an attack? |
|       |
| 1. Were you prescribed medication for this condition?
 | [ ]  Yes (Please provide details.) [ ]  No |
| Name of Medication | Date Prescribed (Month/Year) | Dosage | Date Medication Stopped (Month/Year) | Reason |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| 1. Have you had any investigation/test done regarding this condition?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
| Name of Test or Investigation | Date (Month/Year) | Results |
| [ ]  Barium Meal |       |       |
| [ ]  Colonoscopy |       |       |
| [ ]  Endoscopy |       |       |
| [ ]  Gastroscopy |       |       |
| [ ]  Ultrasound |       |       |
| [ ]  CT Scan/MRI |       |       |
| [ ]  Biopsy |       |       |
| [ ]  Proctosigmoidoscopy |       |       |
| [ ]  Blood Test |       |       |
| [ ]  Others:       |       |       |
| 1. Did you undergo operation or any non-invasive procedure to resolve this condition?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| Type of Surgery/Procedure | Date (Month/Year) | Diagnosis |
|       |       |       |
|       |       |       |
|       |       |       |
| 1. Have you ever been advised further treatment by your physician?
 | [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. When was your last follow-up check-up?
 |
|       |
| 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.**  |

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

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

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

