 **EYE DISORDERS 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 exact diagnosis of your disorder:
 |
| [ ]  Cataract | [ ]  Glaucoma | [ ]  Macular Degeneration |
| [ ]  Others (Please specify.)       |
| 1. Is there a known cause of your disorder or impairment?
 |
| [ ]  No, the cause is unknown. |
| [ ]  Yes (Please specify.) |
| [ ]  Congenital/Present since birth | [ ]  Caused by trauma/accident |
| [ ]  Caused by/associated with another disease (Please specify.)       |
| 1. Please describe the course of the disorder or impairment:
 |
| [ ]  Continuous/Permanent since (mm/dd/yyyy)       |
| [ ]  Episodes |
| [ ]  How many episodes of the disorder have occurred?       episodes |
| [ ]  What is the current status of the latest episode? |
| [ ]  Unresolved/Still present |
| [ ]  Resolved since (mm/dd/yyyy)       |
|  [ ]  How long did the latest episode last?       months |
| **For cases of Glaucoma only:** Has the intraocular pressure been within the normal range over the last five (5) years? [ ]  Yes [ ]  No |
| **For cases of Strabismus only:** When did the disorder first occur? [ ]  Before or at age 18 [ ]  After age 18 |
| 1. If your condition is unresolved, please describe the current status of your disorder or impairment:
 |
| Is your vision currently impaired? |
| [ ]  No [ ]  Yes (Please specify further in Question No. 6.) |
| Have any of the following complications occurred during the course of your disease? |
| [ ]  Peripheral retinal degeneration [ ]  Myopic retinal detachment [ ]  None of these |
| Are other symptoms or residual complications of your disorder still present? |
| [ ]  No. [ ]  Yes (Please specify.)       |
| 1. What treatment have you received?
 |
| [ ]  Medication | [ ]  Laser vision correction | [ ]  Laser treatment of the retina |
| [ ]  Corneal transplant (Please specify.)       |
| [ ]  Have you received treatment with corticosteroid eye drops? |
| [ ]  Is the treatment completed? |
| [ ]  No [ ]  Yes, the treatment was completed on (mm/dd/yyyy)      . |
| [ ]  Others (Please specify.)       |
| **Only For Cases with Current Visual Impairment or Cases of Visual Impairment Corrected Through Surgery** |
| 1. Please give details on your visual impairment:
 |
| Does the condition affect one or both eyes? |
| [ ]  One eye (Please specify.) [ ]  Both eyes |
| [ ]  Right eye only |
| [ ]  Left eye only |
| Is your visual impairment fully compensated? |
| [ ]  No |
| [ ]  Yes (Please specify.)  |
| [ ]  Glasses [ ]  Contact lenses [ ]  Laser vision correction |
| Please specify your visual impairment further: |
| [ ]  Diopter values (without compensation/before correction): |
| Right eye ([ ]  + or [ ]  -)       dpt |
| Left eye ([ ]  + or [ ]  -)       dpt |
| **For cases of Astigmatism only:** Have the cylindrical values been stable during the last five (5) years? |
| [ ]  Yes [ ]  No |
| [ ]  Visual acuity/Visus (Please specify.) |
| [ ]  < 2% (< 0.02) [ ]  ≥ 10 - < 30% (≥ 0.1 - < 0.3) [ ]  ≥ 30 - < 100% (≥ 0.3 - < 1.0) |
| [ ]  ≥ 2 - < 5% (≥ 0.02 - < 0.05) [ ]  ≥ 5 - < 10% (≥ 0.05 - < 0.1) |
|  [ ]  Values unknown |
| 1. Please provide details about the doctors and/or specialists you see for 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:** |       |

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

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