 **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:** |  |

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| **Signature:** |  |

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