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Description automatically generated with medium confidence**GENITO-URINARY 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. | | | | | | | | | |
| Blood in the urine | | | Benign Prostatic Hypertrophy | | | | | Others: | |
| Kidney stones | | | Hydrocele | | | | |
| Pyelonephritis | | | Urinary Incontinence | | | | |
| Glomerulonephritis | | | Renal Failure | | | | |
| Cystitis (UTI) | | | Prostate Cancer | | | | |
| 1. When was the condition diagnosed or when did you first experience symptoms? | | | | | | | |  | |
| 1. Please describe your symptoms: | | | | | | | | | |
|  | | | | | | | | | |
| 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 copy of the result.)  No | | | | | | | | | |
| Name of Test or Investigation | | Date (Month/Year) | | | | | Results | | |
| Blood Exam | |  | | | | |  | | |
| Cystoscopy | |  | | | | |  | | |
| Ultrasound | |  | | | | |  | | |
| X-ray | |  | | | | |  | | |
| CT Scan | |  | | | | |  | | |
| MRI | |  | | | | |  | | |
| Others: | |  | | | | |  | | |
| 1. Are you contemplating on undergoing surgical or any non-invasive procedure as advised by your physician? | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | |

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| Type of Surgery/Procedure | | Proposed Date of Surgery/Procedure  (Month/Year) | | | |
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|  | |  | | | |
| 1. Did you undergo surgery or any non-invasive procedure to resolve this condition? | | | | | |
| Yes (Please provide details.)  No | | | | | |
| Type of Surgery/Procedure | Date (Month/Year) | | | Diagnosis | |
|  |  | | |  | |
|  |  | | |  | |
|  |  | | |  | |
| 1. How often do you go for follow up check-up? | |  | | | |
| 1. Have you ever taken time off work with this condition? | | | Yes (Please provide details.)  No | | |
|  | | | | | |
| 1. Have your working duties ever been affected or restricted in any way? | | | | | |
| Yes (Please provide details.)  No | | | | | |
|  | | | | | |
| 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:** |  |

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

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