MUSCULOSKELETAL QUESTIONNAIRE – APPLICANT

(This questionnaire will form part of the application)

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

1. Please state the precise diagnosis or nature of the condition. Attach a copy of any medical report if available.		
☐ Back Pain	☐ Herniated Disc	☐ Others: _____
☐ Scoliosis	☐ Sciatica	
☐ Fracture	☐ Spondylitis	
☐ Arthritis	☐ Osteoporosis	
☐ Muscle Weakness	☐ Carpal Tunnel Syndrome	

2. When was the condition diagnosed or when did you first experience symptoms?

3. Which particular body part is affected by this condition?

4. What was the underlying cause?		
☐ Accident	☐ Degeneration	☐ Sports-related
☐ Runs in the family	☐ Unknown	☐ Others: _____

5. Do you still experience symptoms?	☐ Yes ☐ No
If no, when did you last experience symptoms or last time you had an attack?	

6. Have you had any recurrence of this condition?	☐ Yes (Please provide details.) ☐ No

Name of Medication	Date Prescribed (Month/Year)	Dosage	Date Medication Stopped (Month/Year)	Reason

7. Have you had any investigation/test done regarding this condition?		
☐ Yes (Please provide details.) ☐ No		
Name of Test or Investigation	Date (Month/Year)	Results
☐ X-ray		
☐ MRI		
☐ CT Scan		
☐ Bone Scan		
☐ Arthroscopy		
☐ Ultrasound		
☐ Others: _____		

8. Please indicate all therapeutic procedures you have had for this condition, (e.g., physical therapy, surgery, casting, etc.)

Type of Surgery/Procedure	Date (Month/Year)	Diagnosis	Current Status

9. Are you contemplating on undergoing surgery, joint replacement or amputation as advised by your physician?

☐ Yes (Please provide details.) ☐ No

Type of Surgery/Procedure	Proposed Date of Surgery/Procedure (Month/Year)

10. Has this condition restricted your physical activities in any way? ☐ Yes (Please provide details.) ☐ No

11. Have you taken time-off work due to this condition? ☐ Yes (Please provide details.) ☐ No

12. Have you been admitted to a hospital/facility due to this condition?

☐ Yes (Please provide details.) ☐ No

Date Admitted (Month/Year)	Date Discharged (Month/Year)	Name of Hospital/Facility	Reason for Confinement

13. Please provide any additional information that you feel is important.

14. 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)

DECLARATION

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:	
Signature:	
Date of Signing:	