VENOUS DISEASES 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.

☐ Varicose veins/Varicosis/Varices	☐ Venous Thrombosis
☐ Post thrombotic Syndrome	☐ Others: _____
☐ Venous inflammation/Phlebitis	

2. Please provide information on the characteristics of the varicose veins, if applicable:

Classification	Characteristics
Mild Form (Grade C1, CEAP-Classification)	☐ Telangiectasias/Spider veins/Hyphen webs/Thread veins (dilation of superficial, smallest blood vessels with a diameter of less than 1 mm) ☐ Reticular veins (enlarged, smaller veins in the lower skin with a diameter of 1 to 3 mm)
Moderate Form (Grade C2, CEAP-Classification)	☐ Varicose veins/Varicosis/Varices (dilated veins with a diameter of more than 3mm)
Severe Form (Grade C3-6, CEAP-Classification)	☐ Edema (swelling and accumulation of fluid in the legs) ☐ Skin pigmentation (brownish skin discolorations) ☐ Eczema (inflammatory skin changes) ☐ Lipodermatosclerosis/LDS (chronic inflammation and fibrosis of the skin and subcutaneous tissue of the lower leg) ☐ Atrophie blanche/White atrophy (localized, circular or star-shaped region of white skin of the leg) ☐ Healed or active venous ulcer of the lower leg

3. Please provide information on the cause of the venous disease?

☐ Immobilization after surgery or trauma	☐ Unknown cause
☐ Thrombophilia	☐ Others: _____

4. Please provide information on the course of the venous disease:

Frequency	Date (Month/Year)	
☐ Single occurrence/one episode of disease	When?	
☐ Multiple occurrences/more than one episode of disease	Last occurred?	
☐ Permanent/chronic occurrence	Since when?	

5. Have you experienced complications of the venous disease, (e.g., embolisms)?

☐ Yes (Please provide details.) ☐ No

6. Have you recovered completely without sequelae from the venous disease?

☐ Yes (Please provide the date.) _____

☐ No (Please specify.)

7. Please provide any additional information that you feel is important.
8. 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:	