ZURICH

Digestive system

Supplementary questionnaire
(to be completed by the life to be insured)

Instructions

Please complete this form to supplement the answers you have given on your proposal. The information you give may assist us in the assessment of your proposal and help minimise the need for medical reports.

Please complete this form in **CAPITAL** letters. All questions must be answered accurately with full disclosure of all relevant information.

If there is insufficient space for any answer, please continue on a separate piece of paper and attach to this questionnaire.

1 Personal details

Full name of life to be insured

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please give details)

Family name

Forename(s)

Date of birth D D M M Y Y Y Y

Proposal number

2 Supplementary questions

Please state whether your condition was given a precise diagnosis (e.g. ulcerative colitis, Crohn's disease, gastric or duodenal ulcer, hernia, Barrett's oesophagus, irritable bowel syndrome, etc.) and attach a copy of any reports if available.

Date of diagnosis Date D D M M Y Y Y Y

Please state the diagnosing doctor's name and address.

Please provide details and dates of any treatment you are currently receiving or have received in the past (e.g. Tagamet, Zantac, Gaviscon).

Date(s)	Treatment(s)

Supplementary questions (continued)

Have you ever taken steroids? (e.g. Colifoam, Predsol). ☐ Yes ☐ No

If 'Yes', please provide details and dates.

Date(s)	Treatment(s)

How often do your symptoms recur? ☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly

Please state the date you last experienced symptoms. Date D D M M Y Y Y Y

Please state the severity and duration of your last experienced symptoms.

Please detail what investigations you have undergone for your condition and provide the doctor's name and address and the results of such investigations (e.g. colonoscopy, gastroscopy, etc.).

Have you undergone any surgery for your condition? ☐ Yes ☐ No

If 'Yes', please give details and dates including the medical name for the operative procedure if known (e.g. colostomy, vagotomy, gastrectomy, ileostomy).

Have there been any complications following the surgery? ☐ Yes ☐ No

If 'Yes', please provide details.

Are you currently being followed-up? ☐ Yes ☐ No

If 'Yes', please state frequency per annum.

Have you been discharged from follow-up? ☐ Yes ☐ No

If 'Yes', please state date of discharge. Date D D M M Y Y Y Y

If 'No,' please state how often you will be reviewed in the future.

Have you at any time been off work with your condition? ☐ Yes ☐ No

If 'Yes', please provide details and dates.

Date(s)	Duration(s)

Supplementary questions (continued)

Please restate your smoking and drinking habits.

Do you smoke? ☐ Yes ☐ No

If 'Yes', what is your daily consumption of tobacco?

Cigarettes ________ Cigars ________ Grammes of pipe tobacco ________

Chewing tobacco ________ Other (please give details) ________

If you have stopped or reduced your smoking, please provide the date this change took place. Date D D M M Y Y Y Y

Please state what your previous smoking habits were.

Do you consume alcohol? ☐ Yes ☐ No

If 'Yes', please provide the number of units consumed a week. ________ units per week

Note: 'social' or 'occasional' are not acceptable answers.

(1 unit = single measure of spirits or one 125ml glass of wine or 250ml beer)

Have you habitually drunk more in the past? ☐ Yes ☐ No

If 'Yes', please give details. ________ units per week

Please provide us with any additional information about your condition that will help us assess your proposal (e.g. dates, names and addresses of doctors/hospitals).

Thank you for completing this form. Please return it to us with your proposal, or if you prefer, in a sealed envelope.

3 Privacy notice

The personal information requested in this form is collected and used by Zurich International Life Limited (the Company) as Data Controller in line with the Data Protection Policy. Full details can be found online at https://www.zurichinternational.com/en/zurich-international-life/about-us/privacy or contact us for a copy.

I declare that the answers given, whether in my handwriting or not, are true and complete to the best of my knowledge and belief. I agree that this form will constitute part of my proposal and that failure to disclose any material fact known to me may constitute grounds for rejection of a claim or repudiation of the contract.

Special category data consent

By signing this form, I consent to the Company processing my medical and health information and authorise the seeking and processing of information from any medical practitioner who has attended me or from any insurer to which an application has been made for insurance. I confirm such authorisation shall remain in force after my death.

Withdrawal of consent

I understand that where I have provided consent I have the right to withdraw the consent at any time and that such withdrawal will not affect the data processing carried out prior to such withdrawal.

Signature of life to be insured

Date D D M M Y Y Y Y

Zurich International Life Limited is registered in Bahrain under Commercial Registration No. 17444 and is licensed as an Overseas Insurance Firm – Life Insurance by the Central Bank of Bahrain.

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