# Health and lifestyle questionnaire

**Completing this form**

Please write clearly in **BLOCK CAPITAL** letters and complete the form in English.

This is a supplementary form to the main application form and should be completed and returned along with the main application form.

**Please ensure all questions are answered fully and honestly. Incorrect or incomplete information could invalidate your insurance claim and your beneficiaries may not receive the claim amount.**

To be completed by the life to be insured.

## 1. Details

Policy number

Name of Policy owner(s)

### Life insured details

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

Family name

Forename(s)

## 2. Health and lifestyle questionnaire

**We may require special questionnaires to be completed which will be provided by your relevant financial professional.**

**1.** Have you smoked or used any form of tobacco or nicotine product within the last 12 months (e.g. cigarettes, cigars, pipe or chewing tobacco, shisha or nicotine products such as patches, gum or ecigarettes)? ☐ Yes ☐ No

If you have smoked or used any form of tobacco or nicotine products in the last 12 months, please provide type, frequency and quantity (e.g. 20 cigarettes a day, one shisha a week, etc).

If you no longer use tobacco or nicotine products, when did you stop using them and what was your previous consumption (e.g. stopped January 2011 – used to smoke 20 cigarettes a day)?

**2.** Do you consume alcohol? ☐ Yes ☐ No

If 'Yes', please provide the number of units consumed each week.

1 unit = single measure of spirits or 125ml glass of wine or 250ml of beer.

**3.** Have you ever been advised to give up tobacco and/or alcohol for a specific reason? ☐ Yes ☐ No

If 'Yes' please provide details.

**4.** What is your height and weight? Height cms Weight kgs

## Health and lifestyle questionnaire (continued)

**Please ensure all questions are answered fully and honestly. Incorrect or incomplete information could invalidate your insurance claim and your beneficiaries may not receive the claim amount.**

**5.** (a) In which industry are you employed?

Industry

(b) What is your occupation?
**For UAE Armed Forces employees, question 1(b) and 1(c) are not applicable. Please proceed to question 1(d).**

Occupation

(c) What percentage of your occupation involves manual work and what is the nature of these duties?

% Duties

If your occupation includes activities that may be considered hazardous (for example – aviation, working at heights, or underground, or with explosives), please complete the relevant 'Oil and natural gas', 'Aviation' or 'General occupation' questionnaire, as appropriate.

(d) Please state your earnings in the last 12 months from employment or business operations. Currency

Amount

(e) Do you participate in any sport or activity that may be considered hazardous? (For example, motor racing, diving, mountaineering, private flying, etc.) ☐ Yes ☐ No

If 'Yes', please complete the relevant questionnaire or, if a specific questionnaire does not exist, please provide us with full details of frequency of activity, level of participation, any qualifications, details of competitions in which you take part, etc. in the 'Additional information' section at the end of this form.

**6. Family history**

Please provide details of your family history below. Of particular importance is where your father, mother or any of your brothers or sisters has died of or suffered from heart disease, cancer, multiple sclerosis or diabetes before the age of 65 or from a familial/hereditary disorder.

| Relation | Age now/Age at death | State of health/Cause of death | Age at onset of disease |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| | | | |
| Sister(s) | | | |
| | | | |

**7.** (a) Please confirm the purpose of this insurance application (ie. personal cover, family protection, mortgage cover, keyman insurance, partnership protection, etc).

(b) Have you any existing life, disability or critical illness cover already in force with Zurich or any other insurance company? ☐ Yes ☐ No

If 'Yes', please complete the details below.

| Insurer | Benefits | Sum insured | Policy term | Start date | Reason for cover |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

(c) Are you intending to replace any of the above covers with this application? ☐ Yes ☐ No

If 'Yes', please advise which will be replaced.

(d) Are you currently applying to Zurich or any other insurance company for further cover? ☐ Yes ☐ No

If 'Yes', please complete the details below.

| Insurer | Benefits | Sum insured | Policy term | Start date | Reason for cover |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## Health and lifestyle questionnaire (continued)

**Please ensure all questions are answered fully and honestly. Incorrect or incomplete information could invalidate your insurance claim and your beneficiaries may not receive the claim amount.**

(e) Have you ever had an application for life, disability or critical illness insurance declined, postponed or accepted at other than normal terms? ☐ Yes ☐ No

If 'Yes', please state the company/ies, benefits and date of application.

| Insurer | Benefits | Date of application | Decision |
|---|---|---|---|
| | | | |
| | | | |

**8.** (a) Have you been resident in your current country of residence for less than 5 years? ☐ Yes ☐ No

If 'Yes', please provide details below.

| City/Country | From | To |
|---|---|---|
| | | |
| | | |

(b) Other than for vacations of less than 15 days in any 12 month period, do you visit or have any intention of visiting, living or working outside of your current country of residence? ☐ Yes ☐ No

If 'Yes', please provide details below.

| Travel to (Country) | Duration of stay | Purpose of stay |
|---|---|---|
| | | |
| | | |

**If you visit or intend to visit Iran, Iraq, Yemen, Afghanistan, Pakistan, Syria, any country of the former Soviet Union or any country in Africa, please complete our 'Travel and residency questionnaire'.**

### 9a. Medical questions

If you answer 'Yes' to any of the questions in '9a. Medical questions', there are special questionnaires for each disorder that you will need to complete. These will be provided by your relevant financial professional. Please ensure the relevant form(s) is/are attached with your application.

Do you have or have you ever been diagnosed as having:

(a) High blood pressure? ☐ Yes ☐ No

(b) Diabetes or impaired fasting glucose? ☐ Yes ☐ No

(c) Asthma, chronic bronchitis or obstructive airways disease? ☐ Yes ☐ No

(d) Spinal (back or neck) disorders, muscular or joint disorders? ☐ Yes ☐ No

(e) Digestive disorders eg. Crohn's Disease, ulcerative colitis, gastric reflux, ulcers, hernia? ☐ Yes ☐ No

(f) Arthritis eg. osteoarthritis, rheumatoid arthritis or gout? ☐ Yes ☐ No

(g) Growths, lumps, cysts, abnormal moles or skin lesions? ☐ Yes ☐ No

(h) Mental health issues eg. depression, anxiety, schizophrenia, eating disorders, bipolar disorder? ☐ Yes ☐ No

### 9b. Medical questions

If you answer 'Yes' to any of the questions in '9b Medical questions' or in questions 10 or 11, please give details in the 'Additional information' section.

Do you have or have you ever been diagnosed as having:

(i) Heart attack, murmur, palpitations, chest pain or high cholesterol? ☐ Yes ☐ No

(j) Paralysis, stroke or transient ischaemic attack? ☐ Yes ☐ No

(k) Thyroid or other glandular disorders? ☐ Yes ☐ No

(l) Skin disorders eg. psoriasis or sexually transmitted diseases? ☐ Yes ☐ No

(m) Epilepsy, fits, multiple sclerosis or other neurological complaints? ☐ Yes ☐ No

(n) Impairment in speech, vision or hearing or other disorder of the ears or eyes? ☐ Yes ☐ No

(o) Cancer or tumours (benign or malignant)? ☐ Yes ☐ No

## Health and lifestyle questionnaire (continued)

**Please ensure all questions are answered fully and honestly. Incorrect or incomplete information could invalidate your insurance claim and your beneficiaries may not receive the claim amount.**

(p) Liver or gall bladder disorders eg. hepatitis (including carrier state), fatty liver, haemochromatosis, cirrhosis, jaundice, gallstones? ☐ Yes ☐ No

(q) Urinary or kidney disorders eg. stones, pyelonephritis, blood or protein in urine? ☐ Yes ☐ No

(r) Anaemia, haemophilia, malaria or other parasitic disease or blood disorders? ☐ Yes ☐ No

(s) Prostate disorders, ovarian or cervical disorders eg. hysterectomy, endometriosis? ☐ Yes ☐ No

(t) Any other disability, illness, operation or injury causing bodily impairment? ☐ Yes ☐ No

**10.** (a) Are you currently taking any medication? ☐ Yes ☐ No

(b) Have you ever had any screenings where the results were abnormal eg. mammograms, cervical smear tests, PSA screenings, chest x-ray? ☐ Yes ☐ No

(c) Have you ever tested positive for HIV or Hepatitis B or C, or are you awaiting the results of such a test? ☐ Yes ☐ No

(d) In the last 5 years, have you been under medical review or follow-ups with a medical specialist, been advised to self-isolate or undergone any medical test or special examination including echocardiogram, ECG, CT angiography, ultrasound, scans, COVID-19, urine or blood tests not mentioned above? ☐ Yes ☐ No

(e) Do you experience any symptoms or conditions for which you have yet to seek medical advice (including persistent cough, fever and/or raised temperature), waiting for a test result or are you planning to undergo medical investigations within the next six months? ☐ Yes ☐ No

**For female clients**

**11.** (a) Are you now pregnant? ☐ Yes ☐ No

If 'Yes', please confirm your due date and provide a statement from your obstetrician to confirm the pregnancy is proceeding normally. Due date D D M M Y Y Y Y

(b) Have you ever had any pregnancy related complications such as pre-eclampsia? ☐ Yes ☐ No

### 12. Details of doctor/clinic/hospital

Please give details of the doctor, clinic or hospital most familiar with your medical history (even if this is in a country other than your current country of residence).

Name of doctor/clinic/hospital

Address of doctor/clinic/hospital

Telephone number

### Additional information

| Question number | Details of disease or disorder, treatment given, date of diagnosis, details of doctor consulted, ongoing symptoms, date of next consultation, etc. If you are in possession of copies of reports in relation to these matters, please submit copies with your application for our consideration. |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

If there is insufficient space, please continue on a separate piece of paper ensuring you sign and date any additional pages.

## 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.

## 4. Declaration/Consent

I understand 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.

I declare that I have reviewed the answers given in this application, whether in my handwriting or not, and that they are true and complete to the best of my knowledge and belief, and will form the basis of my contract of life insurance.

I confirm that this signature is mine or that of my appointed legal representative.

Please remember that this form is in addition to the main application form and by completing and signing this form you agree to the declaration in the main application form.

Signature of life to be insured

Date D D M M Y Y Y Y

Print name





ZURICH