Hypertension

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 application. The information you give will assist us in the assessment of your application and may 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

Policy number (if known)

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

2 Supplementary questions

2.1 Date when the hypertension was first diagnosed. D D M M Y Y Y Y

2.2 Why was your blood pressure measured at this particular time? i.e routine examination, symptoms of hypertension, etc.

2.3 Do you know what the pre-treatment blood pressure readings were? ☐ Yes ☐ No

If 'Yes', please state readings and dates.

Date(s)	Reading(s)

2.4 Were you advised of any underlying cause? (e.g. obesity, smoking, family history, etc.). ☐ Yes ☐ No

If 'Yes', please give details below.

Supplementary questions (continued)

2.5 What treatment was or has been prescribed by your doctor?

Please tick accordingly and provide details:

☐ Oral Medication

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

☐ Diet and exercise only

☐ Others, please provide details: _____

Please specify date of last treatment (if applicable) Date D D M M Y Y Y Y

2.6 Are you aware of any complications (such as other medical conditions)? ☐ Yes ☐ No

If 'Yes', please give details.

_____

2.7 Have you had any of the following tests done? ☐ Yes ☐ No

If 'Yes', please tick the tests that you have done.

	Results	Date
☐ Cholesterol (Total)		
☐ Ratio: Total/HDL		
☐ Chest X-ray		
☐ ECG		
☐ Exercise ECG		
☐ Echocardiogram		
☐ Angiogram		
☐ Nuclear scan		
☐ Others – Please specify		

2.8 Have any abnormalities, such as protein, blood, or sugar, ever been found in your urine? ☐ Yes ☐ No

If 'Yes', please provide date(s) and full details.

_____

2.9 Do you suffer from any related problems e.g. raised cholesterol, diabetes, heart, kidney or eye problems? ☐ Yes ☐ No

If 'Yes', please give details.

_____

Supplementary questions (continued)

2.10 Please confirm the name, address and contact details of the doctor now treating you for hypertension.

2.11 Please confirm how often you visit your doctor to have your blood pressure checked.

2.12 Please confirm the date on which you last saw your doctor to have your blood pressure monitored. D D M M Y Y Y Y

2.13 Please confirm what the blood pressure reading was.

2.14 Please confirm your blood pressure readings from the previous three consultations if known.

Date of Consultation	Reading

2.15 Please provide any additional information on your condition which you feel will be helpful in processing your application.

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.

4 Declaration/consent

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.

If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.

Signature of life to be insured

Date D D M M Y Y Y Y

ZURICH