# Mental health

## Supplementary questionnaire (to be completed by the insured person)

### 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 the 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 indicate the nature of your condition (i.e. anxiety, depression, bipolar disorder, schizophrenia, eating disorders, alcohol or drug addiction, etc.).

Please state the date you first suffered from your condition. Date D D M M Y Y Y Y

Please state the date you first consulted your doctor. Date D D M M Y Y Y Y

Please provide name and contact details for doctors clinics or psychiatrists consulted.

| Date(s) | Details of doctor(s) |
|---|---|
| | |
| | |

Have you experienced any recurrence since the date you first suffered from your condition? ☐ Yes ☐ No

If 'Yes', please state how often including dates.

## Supplementary questions (continued)

Are you currently receiving any treatment (medication or counseling etc)? ☐ Yes ☐ No

If 'Yes', please give details.

How often are you currently reviewed by the doctor/psychiatrist counselor?

Please provide details and dates of any medication you have received in the past (e.g. Valium, Lithium).

| Treatment | Dosage | Date(s) |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever had time off work due to your condition, or have your working duties ever been affected or restricted in any way? ☐ Yes ☐ No

If 'Yes', please provide details.

Have you ever received treatment for your condition from a source other than a doctor (e.g. support group/out patient department/in patient/counselling)? ☐ Yes ☐ No

If 'Yes', please provide details, names, addresses and dates.

Have you ever been admitted to hospital in respect of your mental illness? ☐ Yes ☐ No

If 'Yes', please provide dates and details of treatment received, in particular, the doctor's names and addresses.

| Date(s) | Treatment | Details of doctors |
|---|---|---|
| | | |
| | | |
| | | |

Did your condition develop as a reaction to a particular circumstance? ☐ Yes ☐ No

If 'Yes', please outline those circumstances.

Did your condition fully resolve once these circumstances had passed? ☐ Yes ☐ No

If 'Yes', please advise date of resolution/last treatment. Date D D M M Y Y Y Y

Have you ever attempted to take your own life? ☐ Yes ☐ No

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

Please provide us with any additional information about your condition that will help us to process your proposal more quickly (e.g. 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.

## 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 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 insured person

Date D D M M Y Y Y Y





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