SECTION C - Supplementary pages

Health declaration

These questions need to be answered by everyone who is:

- applying for a new policy, or
- making changes to an existing policy.

Important: You must complete this section for each applicant. If you need more space, please see our website for supplementary pages.

9 Heart conditions

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for angina/chest pain, heart attack, heart failure, abnormal heart beat, arrhythmia, heart murmur or rheumatic fever?

◯ Yes ◯ No (go to Q10) ◯ Yes ◯ No (go to Q10)

	Name of participant:	Name of participant:
Please provide details of the cardiac disorder.		
When did you first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms of this condition?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations and/or treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any residual effects?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Do you require any on-going treatment, medication and/or monitoring?	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:

If you require more space to write, please use pages 29-31.

10 Raised blood pressure; raised or abnormal cholesterol

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for raised blood pressure or raised or abnormal cholesterol?

◯ Yes ◯ No (go to Q11) ◯ Yes ◯ No (go to Q11)

	Name of participant:	Name of participant:
Do you suffer from or have you been advised by a medical practitioner that you suffer from:	◯ Raised blood pressure ◯ Raised or abnormal cholesterol	◯ Raised blood pressure ◯ Raised or abnormal cholesterol
When did you first become aware you had raised blood pressure?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you first become aware you had abnormal cholesterol?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment and/or medication have you been prescribed?		
Has your treatment changed in the last 12 months?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
How often is your blood pressure and/or cholesterol checked and by whom?		
What were your three most recent blood pressure readings and cholesterol results?	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR
Have you ever been admitted to hospital or consulted a specialist or been referred to a specialist as a result of your blood pressure and/or cholesterol readings?	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:
Do you suffer from any complications or associated conditions?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 29-31.

11 Breathing or respiratory disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis, emphysema or sleep disorders?

◯ Yes ◯ No (go to Q12) ◯ Yes ◯ No (go to Q12)

	Name of participant:	Name of participant:
Please provide details of the breathing disorder (e.g. asthma, bronchitis).		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
What treatment and/or medication have you been prescribed?		
How frequent are/were the symptoms?	_____ per month/per year (delete one)	_____ per month/per year (delete one)
Do you consider your breathing disorder to be:	◯ Mild ◯ Moderate ◯ Severe ◯ Other	◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you been hospitalised and/or been on a nebuliser in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been prescribed steroids (e.g. prednisone) in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to a specialist for investigations and/or treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 29-31.

12 Digestive disorders; stomach, intestine, liver or gall bladder problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for gastritis, ulcers, reflux, irritable bowel, Crohn's disease, colitis, coeliac disease, bowel polyps, abdominal pain, pancreatitis, liver inflammation, fatty liver, cirrhosis, gallstones or hernias?

◯ Yes ◯ No (go to Q13) ◯ Yes ◯ No (go to Q13)

	Name of participant:	Name of participant:
Please provide details of the type of digestive disorders and/ or stomach, intestine, liver or gall bladder problems.		
When did you first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Do you still experience symptoms of this condition?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations of the gastrointestinal tract (e.g. gastroscopy, endoscopy, colonoscopy)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you undergone or been advised to undergo any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome:	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome.
Have you in the past or are you currently taking any medication for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 29-31.

13 Cancer, cysts, tumours or growths

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for polyps, benign growths, any cancers or pre-cancerous condition, suspicious moles, cysts, abscesses, ganglion, basal cell carcinoma or melanoma?

◯ Yes ◯ No (go to Q14) ◯ Yes ◯ No (go to Q14)

	Name of participant:	Name of participant:
Please provide details of the condition.		
Please advise the name of the medical condition.		
When did you first experience symptoms or become aware of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment was undertaken or advised? If surgical removal, please provide date.		
If no treatment was undertaken, is the condition still present?	◯ Yes ◯ No	◯ Yes ◯ No
Do you know if the condition was:	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure
Has there been any recurrence?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you seen a specialist, do you require any on-going follow-up, treatment or monitoring or has any follow-up/further treatment been recommended?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 29-31.

14 Muscle or skeletal problems (including cartilage, tendon and ligament problems)

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for arthritis, back pain, neck/shoulder problems, whiplash, sciatica, scoliosis, ankylosing spondylitis, OOS, RSI, carpal tunnel, joint replacements, fractures, osteoporosis, gout or inflammatory conditions or any disorders of the hips, knees, ankles, feet, toes, shoulders, arms, elbows, wrists, hands or fingers?

◯ Yes ◯ No (go to Q15) ◯ Yes ◯ No (go to Q15)

	Name of participant:	Name of participant:
What is the name of the condition/ complaint/injury?		
What body part is affected? Please indicate if left or right limb.		
When did you first suffer from this condition/complaint/injury, and how did it occur?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
How long did the symptoms last?		
When did you last suffer from symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Has this condition occurred more than once?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you had any investigations?	◯ Yes ◯ No If **yes**, please provide details of type, date and results:	◯ Yes ◯ No If **yes**, please provide details of type, date and results:
Have you had any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details including date:	◯ Yes ◯ No If **yes**, please provide details including date:

If you require more space to write, please use pages 29-31.

Muscle or skeletal problems (continued)

	Name of participant:	Name of participant:
Have you had any time off work or school as a result of this condition?	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DAY / MONTH / YEAR	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DAY / MONTH / YEAR
Have you made a claim to ACC in respect of this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you currently receiving treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery will be required?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any pain or discomfort since the last episode/ symptoms?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you aware of any arthritis or degeneration in the affected body part(s)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 29-31.

15 Blood, immune or circulatory disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for abnormal blood tests, anaemia, hepatitis, HIV, haemochromatosis, vitamin B12 deficiency, haemophilia, lupus or any autoimmune disorder or varicose veins, DVT or blood clots?

	◯ Yes ◯ No (go to Q16)	◯ Yes ◯ No (go to Q16)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

16 Endocrine (glandular) disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for diabetes (type 1 or type 2), thyroid problems, Graves' disease, abnormal thyroid function tests, pituitary problems or abnormal blood sugar and/or glucose tolerance tests?

◯ Yes ◯ No (go to Q17) ◯ Yes ◯ No (go to Q17)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

17 Urinary or kidney disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for kidney or bladder problems, incontinence, urinary difficulties, kidney stones or kidney infections, kidney failure or recent and/or recurrent UTIs?

	◯ Yes ◯ No (go to Q18)	◯ Yes ◯ No (go to Q18)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

18 Anal/rectal problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for haemorrhoids, change in bowel habit, anal fissures, anal bleeding or pilonidal sinus?

◯ Yes ◯ No (go to Q19) ◯ Yes ◯ No (go to Q19)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

19 Skin problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for eczema, dermatitis, rashes, psoriasis, acne or allergic conditions?

	◯ Yes ◯ No (go to Q20)	◯ Yes ◯ No (go to Q20)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

20 Brain or nervous system disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for stroke, TIA, aneurysms, migraine, repeated headaches, vertigo, fainting, dizziness, multiple sclerosis, epilepsy/seizures, paralysis, motor neuron disease, nerve pain or meningitis?

	◯ Yes ◯ No (go to Q21)	◯ Yes ◯ No (go to Q21)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

21 Fatigue or pain syndromes

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for chronic fatigue, fibromyalgia or chronic pain syndrome?

	◯ Yes ◯ No (go to Q22)	◯ Yes ◯ No (go to Q22)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

22 Eye, ear or throat problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for cataracts, glaucoma, visual impairment, hearing loss, tinnitus, recent and/or recurrent ear infections, grommets, enlargement of adenoids, tonsillitis or recent and/or recurrent throat infections?

◯ Yes ◯ No (go to Q23)

◯ Yes ◯ No (go to Q23)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

23 Allergies, nasal and/or sinus problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for anaphylaxis, nasal obstruction, hay fever, sinusitis or recent and/or recurrent sinus infections?

	◯ Yes ◯ No (go to Q24)	◯ Yes ◯ No (go to Q24)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

24 Dental problems

Have you, or any of the participants to be insured, ever had oral surgery or experienced, had symptoms of, been treated for or been advised to seek testing or treatment for wisdom teeth, impacted or unerupted teeth, cysts or gum disease?

	◯ Yes ◯ No (go to Q25)	◯ Yes ◯ No (go to Q25)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
If wisdom teeth have been removed, please confirm how many.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

25 Mental health conditions

Have you, or any of the participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the participants to be insured, currently receiving or have ever received counselling, investigations or treatment for, any psychiatric or psychological condition, including anxiety, stress or depression?

◯ Yes ◯ No (go to Q26 for males or Q27 for females)

◯ Yes ◯ No (go to Q26 for males or Q27 for females)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

26 To be completed by males only

Have you, or any of the male participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the male participants to be insured, currently receiving or have ever received counselling, investigations or treatment from a health professional for, any of the following: blood in the urine, slow urinary stream, problems with passing urine, disease or disorder of the testicles, bladder, urethra or prostate, sexual dysfunction or abnormal prostate tests?

◯ Yes ◯ No (go to Q28) ◯ Yes ◯ No (go to Q28)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

27 To be completed by females only

Have you, or any of the female participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the female participants to be insured, currently receiving or have ever received counselling, investigations or treatment from a health professional for, any of the following: breast disease or disorder, breast lumps, cysts or breast pain, gynaecological disorder of any kind, endometriosis, polycystic ovarian syndrome, irregular, heavy or painful menstrual bleeding, current symptoms of menopause, ovarian or hormonal problems, complications of pregnancy, abnormal smear(s), painful intercourse and/or prolapse?

◯ Yes ◯ No (go to Q28) ◯ Yes ◯ No (go to Q28)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

28 Other conditions

Have you, or any of the participants to be insured:

- ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for any other illness, accident, injury, condition, complaint, disability, medication or disorder not already stated?
- been hospitalised or had any tests, medical treatment or investigations in the last five years or be intending to for **any condition not already stated**, including but not limited to blood and/or urine test, X-ray, ultrasound, CT scan, mammogram, MRI, gastroscopy, colonoscopy, endoscopy, hysteroscopy and laparoscopy?
- had more than five consecutive days off work or school in the past five years due to **any condition not already stated**?
- ever had elective surgery for any reason?

◯ Yes ◯ No (go to Q29) ◯ Yes ◯ No (go to Q29)

	Name of participant:	Name of participant:
Please advise the name of the medical condition, treatment and/or surgery.		
When did you first experience symptoms? If elective surgery, when did you first receive treatment?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 29-31.

29 Family history (please answer both questions below)

Have you, or any of the participants to be insured, ever undertaken testing or treatment, or been advised to seek testing or treatment in relation to family history?

◯ Yes ◯ No (go to the question below) ◯ Yes ◯ No (go to the question below)

	Name of participant:	Name of participant:
Please advise the name of the medical condition tested, the reason why the testing was required and the outcome		

Have any of your grandparents, parents, brothers, sisters or children (living or dead) had or been diagnosed with any of the following: cancer, stroke, heart disease, diabetes, kidney disease, Huntington's chorea, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, bowel and/or colon polyps, multiple sclerosis, inherited neurological or blood disease or any familial and/or congenital disease or disorder?

◯ Yes ◯ No (go to Section D) ◯ Yes ◯ No (go to Section D) ◯ Yes ◯ No (go to Section D) ◯ Yes ◯ No (go to Section D)

	Name of participant:	Name of participant:	Name of participant:	Name of participant:
Medical condition (If cancer, specify type and site)				
Family member affected Please specifcy which side of the family ie: maternal/paternal				
Age at diagnosis				
Current age				
Age at death (if applicable)				

If you require more space to write, please use pages 29-31.

Once you have completed all health questions, please go to Section D (page 32).

Please use the next three pages if you require more space to answer any of the health questions.
Make sure you include the question number (e.g. Q8) and the participant's name.