SUPPLEMENTARY QUESTIONNAIRE

Name of applicant

Reference number

Date of birth (D D M M Y Y Y Y)

Please supply details in connection with

1. What symptoms did you have?	
2. On which date did the symptoms first occur?	
3. What treatment/procedures was prescribed by your doctor?	
4. What was the final diagnosis?	
5. Do you have any implant/fixation devices?	
6. What was the date of your last treatment/procedure?	
7. Are you currently using any medication for this condition?	
8. Do you have any functional impairment due to this condition?	
9. Are you planning any surgical procedure for this condition in the next 12 months. If yes, please supply specifics.	
10. Name, practice number and contact details of the treating doctor	
11. Name, practice number and contact details of your current doctor, if not the same as the treating doctor	

No payment under LOA protocol

DECLARATION BY APPLICANT

I declare that all statements I have made and details I have supplied on this form (whether in my own handwriting or not) are complete and true. I also understand and agree that the information I have supplied, together with the application for health care cover and any other relevant documents, will form the basis of the proposed contract.

Signed at

Date (D D M M Y Y Y Y)

Signature of applicant