AXA MANSARD
redefining / standards

NON–MEDICAL QUESTIONNAIRE

(TO BE COMPLETED TOGETHER WITH THE PROPOSAL FORM)

1. NAME IN FULL: ……………………………………………………………………………………………….

   ADDRESS: ……………………………………………………………………………………………

   ………………………………………………………………………………………………………

   OCCUPATION: ………………………………………………………………………………………

2. HEIGHT: …………………………………….. METRES (IN SHOES)
   WEIGHT: …………………………………… KILOGRAMS (IN INDOOR CLOTHES)
   WHAT IS YOUR PRESENT STATE OF HEALTH? ....
   WHAT IS YOUR GENERAL STATE OF HEALTH? ....
   DO ANY OF THEM VARY? ....

3. HAVE YOU SUFFERED FROM ANY SERIOUS PERSONAL ACCIDENT INVOLVING FRACTURED SKULL OR BONES OR UNCONCIOUSNESS OR OTHER INJURY? (YES/NO)………………

4. HAVE YOU CONSULTED ANY DOCTOR OR CHEMIST WITHIN THE LAST 5 YEARS? (YES/NO)…………if YES FOR WHAT PARTICULAR PROBLEMS? ....

   ……

5. WHAT SERIOUS MEDICAL COMPLAINTS HAVE YOU HAD IN YOUR LIFE?...........................
   ………………………………………………………………………………………………………
   HAVE YOU EVER ATTENDED ANY HOSPITAL OR CLINIC AS EITHER AN OUT-PATIENT OR IN-PATIENT? IF SO, WHERE, WHEN AND WHY?..
   ………………………………………………………………………………………………………

   HAVE YOU AT ANY TIME TAKEN TABLETS OR MEDICINES OVER A PERIOD OF ONE MONTH OR MORE UNDER PRESCRIPTION FROM A DOCTOR?...

   HAVE YOU EVER EXCEEDED THE PRESCRIBED DOSE?...

6. HAVE YOU HAD ANY X-RAYS, INCLUDING MASS X-RAYS AND DEEP X-RAY THERAPY OR ANY BLOOD TESTS OR SPECIAL INVESTIGATION SUCH AS ELECTRICAL HEART OR BRAIN TESTS?..

7. DO YOU WAKE UP AT NIGHT TO PASS URINE?...
   IF SO, ABOUT HOW MANY TIMES A NIGHT?..
   FOR HOW LONG?...

8. (a) HAVE YOU RECEIVED MEDICAL ADVICE OR TREATMENT IN CONNECTION WITH AIDS*(Acquired Immune Deficiency Syndrome)* OR AN AIDS-RELATED CONDITION OR A SEXUALLY TRANSMITTED DISEASE? (YES/NO)……………………………………………..

   (b) HAVE YOU EVER HAD OR BEEN ADVISED TO HAVE A BLOOD TEST FOR AIDS OR AN AIDS RELATED CONDITION? (YES/NO)…………………………………………………

   (C) DO YOU HAVE ANY OF THE FOLLOWING, WHICH ARE UNEXPLAINED? *Fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions?*

   (a) HAVE YOU BEEN TOLD YOU HAD AIDS OR AIDS RELATED COMPLEX? (YES/NO)………..……

(Give full details below including the following: Nature and Details of illness or other condition: Dates and Duration: Time of work: Doctor of Hospital attended).

9. HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?

(a) Anxiety state, depression or nervous breakdown, fits, loss of consciousness.

(b) Disease of the eyes, ears, nose or throat.

(c) Asthma, bronchitis, pneumonia, pleurisy, tuberculosis, chronic cough or spitting of blood

(d) Breathlessness, chest pain or discomfort.

(e) Varicose veins

(f) Dyspepsia or indigestion, gastric or duodental ulcer, colitis, jaundice, liver or pancreatic disorders.

(g) Nephrities, kidney stones, tumor or urinary track abnormalities.

(h) Gonorrhea, syphilis, non-specific urethritis, stricture, prostatitis or enlarge prostate.

(i) Ruptured hernia, fistula or piles.

(j) Diabetes

(k) Rheumatic fever, rheumatism or gout.

IS THERE ANY THING YOU HAVE SUFFERED FROM WHICH HAS NOT BEEN MENTIONED ABOVE?

IN THE CASE OF FEMALE LIVES ONLY

10. ARE YOUR PERIODS REGULAR AND NATURAL?

11. HAVE YOU SUFFERED ANY UTERINE OR OVARIAN DISEASE OR DISPLACEMENTS OR HAD ANY GYNAECOLOGICAL OPERATIONS?

12. HOW MANY CHILDREN HAVE YOU GIVEN BIRTH TO? HAVE YOU HAD ANY MISCARRIAGES, STILL BIRTHS OR DIFFICULT CHILD DELIVERY?

13. ARE YOU PREGNANT? IF SO, PLEASE GIVE EXPECTED DATE OF DELIVERY.

I, ………………………. ………………………………………………….., THE LIFE TO BE ASSURED DO AGREE AND DECLARE THAT ALL THE FOREGOING ANSWERS ARE TRUE AND THAT ANY CONCEALMENT OF MATERIAL FACT WILL INVALIDATE THE CONTRACT

Signature of Proposer: ……….……………………………………. *Date:* ……………………………

Relationship Manager: ………………………………………….… *Date:* ……………………………