

Respiratory

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 insured person

Title Mr Mrs Miss Ms Dr Other (please give details)

Family name

Forename(s)

Date of birth

Proposal number

2 Supplementary questions

Please state which condition you suffer from (e.g. asthma, bronchitis, emphysema, etc.).

When was your condition diagnosed?

Date

When was the date of your last attack?

Date

How frequently do you suffer attacks?

Daily Weekly Fortnightly Monthly Other – please provide details below

Are your attacks precipitated by anything in particular (e.g. dust mites, pollen, exercise).

Supplementary questions (continued)

Have you ever been admitted to hospital in relation to your respiratory disease?

Yes No

If 'Yes', please state duration and dates of stay.

Have you undergone any hospital investigations? (e.g. chest X-ray).

Yes No

If 'Yes', please give details and dates.

How often do you visit the doctor to have your condition monitored?

Please provide the name and address of the doctor who is monitoring your condition.

Please confirm the date of your last respiratory check up with this doctor.

Please confirm the results of any peak flow or spirometry tests performed at your last check up with this doctor.

Please provide details of any treatment or medication you are currently receiving. (e.g. Ventolin, Becotide, Intal).

Have you ever been prescribed steroids and/or treated with oxygen therapy?

Yes No

If 'Yes', please state duration, dates and name of the treatment prescribed (e.g. Prednesol, Prednisolone).

Have you at any time been off work as a result of your condition?

Yes No

If 'Yes', please state dates and duration.

Do you use a Peak Flow meter and record the results at home?

Yes No

If 'Yes', please quote your lowest and highest readings in the last three months.

Do your symptoms wake you up at night?

Yes No

If 'Yes', how often a month?

Please restate your smoking habits.

What is your daily consumption of tobacco?

Cigarettes

Cigars

Grammes of pipe tobacco

Chewing tobacco

Other (please give details)

If you are an ex-smoker, please state the date you gave up and your previous daily consumption.

Please provide us with any additional information about your condition that will help us assess your proposal (e.g. dates, 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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