

GASTRO-INTESTINAL CONDITIONS QUESTIONNAIRE

(To be completed by the life insured)

1. Life insured's details

Policy no. _____ Identity no. _____
 Name of insured _____

2. General information

- 2.1 What is the nature of your symptoms? Diarrhoea Vomitting Heartburn
 Abdominal pain Jaundice Black stools Other

Please specify if 'Other' _____

- 2.2 When did the symptoms first start?

D	D	M	M	Y	Y	Y	Y
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- 2.3 When did your symptoms last occur?

D	D	M	M	Y	Y	Y	Y
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- 2.4 How often do they occur? Daily Weekly Monthly Yearly

- 2.5 Has a medical attendant investigated your symptoms? YES NO

- 2.6 What investigations were done? Gastroscopy Colonoscopy Barium meal Other

Please specify if 'Other' _____

- 2.7 What was the medical attendant's diagnosis?

- Hiatus hernia Spastic colon Diverticulitis Ulcerative colitis
 Ulcer Crohn's disease Pancreatitis Liver disorder
 Oesophageal disorder Barrett's oesophagitis Irritable bowel syndrome Other

Please specify if 'Other' _____

- 2.8 Are you currently receiving treatment for the above condition(s)? YES NO

- 2.9 When last did you receive treatment for the condition(s)?

- Less than 12 months ago 12 to 36 months ago 36 to 60 months ago More than 60 months ago

- 2.10 Provide details of any medication prescribed for your condition(s), including the dosage
- _____

- 2.11 a. Have you ever been hospitalised or undergone surgery for this condition? YES NO

- b. If YES, provide the date of the last time you were hospitalised

D	D	M	M	Y	Y	Y	Y
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- 2.12 Has anyone in your family ever suffered from a gastro-intestinal condition? YES NO

- 2.13 a. Have you ever had an ECG? YES NO

- b. If YES, were the results normal? YES NO

- c. If NO, please advise Doctor who did the ECG. _____

Initials

3. Declaration by life insured

I declare that the statements above are true and complete and shall form part of my application for insurance and I declare that the statements together with my application shall be the basis of the contract between me and Hollard Life.

I authorise Hollard Life to approach any doctor or medical institution to confirm the details of my medical history.

Please take note of the following Hollard disclosures

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature
(life insured)

Date

D	D	M	M	Y	Y	Y	Y
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