# MENTAL HEALTH QUESTIONNAIRE

(To be completed by the medical attendant)

Please return this completed form with any relevant copies to ds_uwrequirements@hollard.co.za.

## 1. Life insured's details

Policy no. _____ Identity no. _____

Name of insured _____

1.1 When did the symptoms of the applicant's condition first occur? State month, year and duration

_____

1.2 What were the symptoms?

a. Physical, e.g. weight loss, loss of appetite, fast pulse, stomach trouble

_____

b. Mental, e.g. insomnia, anxiety, worry, depression

_____

1.3 When did the symptoms last occur? | D | D | M | M | Y | Y | Y | Y |

1.4 In your opinion, what caused the condition and relapses? _____

1.5 What was the final diagnosis made by you? _____

1.6 What treatment/type of medication is he/she currently taking? State dosage of medication and type of other treatment(s) if applicable

_____

_____

1.7 What treatment/medication did he/she receive in the past? State dosage and type of medication and type of other treatment(s) if applicable

_____

_____

1.8 For how long has the applicant been on treatment/medication? _____

1.9 Has he/she ever been absent from work as a result of his/her condition? YES ☐ NO ☐

If YES, confirm dates and for how long? _____

1.10 Has he/she ever been hospitalised? YES ☐ NO ☐

If YES, give dates and for how long? _____

_____

1.11 Is there anyone in the applicant's family who suffers from a nervous or mental condition? YES ☐ NO ☐

If YES, give details

_____

_____

Initials _____

1.12 Has the applicant ever attempted suicide? YES ☐ NO ☐

If YES, give details

1.13 Has the applicant undergone any special examinations, tests or investigations? YES ☐ NO ☐

If YES, give details and results

1.14 Is he/she completely cured and has he/she fully recovered? YES ☐ NO ☐

Provide details

1.15 Give the name(s) and address(es) of the doctor(s) and other specialists who have treated the applicant

## 2. Notice to medical attendants

**Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1403 (General practitioner) , A1450 (Specialist).**

Full name

Qualifications Practice no.

Work tel. no. Cell no.

Email address

Postal address

Please send your account to ds_doctoraccount@hollard.co.za.

Initials

## 3. Declaration by medical attendant

I declare that the statements above are true and complete.

**Signature (medical attendant)** _____ **Date** | D | D | M | M | Y | Y | Y | Y |

## Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.