

## A. MENTAL HEALTH QUESTIONNAIRE

**Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement and have been directed to do so to be considered for insurance cover.**

### MEMBER DETAILS

BT Member number

Title

Given name(s)

Surname

Daytime phone number

1. Please indicate the condition(s) you have had or received treatment for:

- |                                                                                          |                                                                    |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Anxiety including generalised anxiety, panic or phobic disorder | <input type="checkbox"/> Post traumatic stress                     |
| <input type="checkbox"/> Eating disorder including anorexia nervosa, bulimia             | <input type="checkbox"/> Schizophrenic or other psychotic disorder |
| <input type="checkbox"/> Depression including major depression or mild depression        | <input type="checkbox"/> Stress, sleeplessness, chronic tiredness  |
| <input type="checkbox"/> Manic depressive illness, bi-polar disorder                     | <input type="checkbox"/> Other (please specify)                    |
| <input type="checkbox"/> Alcohol or other substance abuse or addiction                   |                                                                    |

2. Describe your symptoms including the date started and how long they lasted:

Symptoms

  
  

Date from

Date to

3 a. Has any reason for your condition been identified or are there any factors which trigger your condition? Yes  No

*If 'Yes', please provide details*

b. Have you ever had suicidal thoughts or attempted suicide? Yes  No

*If 'Yes', please provide details*

4 a. Date your symptoms commenced

b. Have you had any recurrences of this condition? Yes  No

*If 'Yes', please state how many times and when*

5 a. Please advise all treatments you have received and/or are receiving including counselling, name(s) of medications, hospitalisation etc.

Type of treatment

  
  

Date from

Date to

b. Are you currently receiving treatment? Yes  No

*If 'Yes', please provide details*

  

6. Please provide details of doctors or health professionals, including psychiatrists, psychologists, consulting for your condition.

Name and address

  

Date of first consultation

Date of last consultation

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition? Yes  No

*If 'Yes', please state when and for how long*

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? Yes  No

*If 'Yes', please provide details*

## B. SPINAL/JOINTS DISORDER QUESTIONNAIRE

**Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement and have been directed to do so to be considered for insurance cover.**

### MEMBER DETAILS

BT Member number

Title

Given name(s)

Surname

Daytime phone number

1. Area of the spine (eg neck, upper or lower back) and/or joints affected (eg left knee, right hip, shoulders, elbows etc.)

2. Please state precise diagnosis.

3. When did symptoms first occur?

4 a. What was the cause?

b. Please describe your symptoms.

c. Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? Yes  No

d. State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms?

Yes  No

a. If 'No', date last experienced symptoms  /  /

b. If 'Yes', how frequently have symptoms occurred since commencing treatment?

6 a. What is the nature of the treatment (eg medication, physiotherapy, exercise, etc.)?

b. Are you still receiving treatment?

Yes  No

i. If 'No', when did you cease treatment  /  /

ii. If 'Yes', how often do you attend for follow-up and date of last consultation?  /  /

c. Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition?

Yes  No

If 'Yes', please provide details.

Date	Type of investigations	Results	Doctor's Details

8. Have you had an operation for this condition or is an operation being considered?

Yes  No

If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9 a. Have you been off work due to your symptoms?

Yes  No

If 'Yes', when and for how long?

b. Are your occupation duties restricted in any way?

Yes  No

If 'Yes', please provide details.

c. Is it necessary to avoid lifting or to restrict your daily activities in any way?

Yes  No

If 'Yes', please provide details.



## D. CHECK-UP QUESTIONNAIRE

**Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement and have been directed to do so to be considered for insurance cover.**

### MEMBER DETAILS

BT Member number

Title

Given name(s)

Surname

Daytime phone number

1. Please state the reason(s) for your regular check-up/blood test.


2. Please state the dates of your last two check-ups

and

3. Were any tests or further investigations performed?

Yes

No

*If 'Yes', please provide details or attach copies of reports*

Date	Type of tests/investigations	Results

4. Was any treatment prescribed?

Yes

No

*If 'Yes', please provide details*

Date	Type of treatment (eg medications & dosages, physiotherapy, procedures etc).

5. Are you required to return for a follow up?

Yes

No

*If 'Yes', please state when and the reason*