

A. MENTAL HEALTH QUESTIONNAIRE

Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement Part 2 and have been directed to do so to be considered for insurance cover.

INVESTOR DETAILS

BT investor number

C

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 | <input type="text"/> |

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 Part 2 and have been directed to do so to be considered for insurance cover.

INVESTOR DETAILS

BT investor number

C

Title

Given name(s)

Surname

Daytime phone number

()

1. Area of the spine (e.g. neck, upper or lower back) and/or joints affected (e.g. 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', when did you cease treatment / /

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

6 a. What is the nature of the treatment (e.g. 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

C. MULTI-PURPOSE QUESTIONNAIRE (may be photocopied for additional conditions)

Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement Part 2 and have been directed to do so to be considered for insurance cover.

INVESTOR DETAILS

BT investor number

C

Title

Given name(s)

Surname

Daytime phone number

()

1. Name of condition (<i>exact diagnosis</i>)	<input type="text"/>
2 a. What part of the body was affected?	<input type="text"/>
b. Please state which side	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Not applicable
3. What was the cause?	<input type="text"/>
4 a. Date your symptoms commenced	<input type="text"/> / <input type="text"/> / <input type="text"/>
b. How long have you been free of symptoms?	<input type="text"/>
c. How often do/did you have symptoms?	<input type="text"/>
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? <i>If 'Yes', please state when, duration and reason/restriction.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
6. Have you any residual, on-going effects or restriction in your daily activities? <i>If 'Yes', please give details</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
7 a. Have you taken regular or occasional medication for this condition? <i>If 'Yes', advise names of medication(s), dosage(s) and frequency</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
b. Are you still taking this medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Have you had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Have you had any diagnostic investigations (e.g. scope, scan, x-rays, EEG, ECG etc)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Have you ever been in hospital or received emergency treatment for anything related to this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you seen a doctor or other therapist for anything related to this condition? <i>If 'Yes', please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If you answered yes to questions 8 – 11 please advise details including date, type of treatment and tests.</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
12. Has further treatment been recommended for this condition? <i>If 'Yes', please give details</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
13. Does your usual doctor have details of this condition? <i>If 'No', please provide name and address of doctor who has full details</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>

D. CHECK-UP QUESTIONNAIRE

Note: This questionnaire should only be completed if you have answered all questions in the Personal Statement Part 2 and have been directed to do so to be considered for insurance cover.

INVESTOR DETAILS

BT investor number

C

Title

Given name(s)

Surname

Daytime phone number

()

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

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

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

/ /

and

/ /

3. Were any tests or further investigations performed?

If yes, please provide details or attach copies of reports

Yes No

Date	Type of tests/investigations	Results
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Was any treatment prescribed?

If yes, please provide details

Yes No

Date	Type of treatment (e.g. medications & dosages, physiotherapy, procedures etc).
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

If yes, please state when and the reason

/ /

Yes No

<input type="text"/>
<input type="text"/>