



Existing Medical Conditions Questionnaire

ONCE COMPLETED PLEASE FAX TO 0871 277 1422 OR EMAIL : QUOTES@PLATINUMIFA.CO.UK

| | |
|---|--|
| Name | |
| Date of birth | |
| Height and weight: | |
| Sum Assured & Term: | |
| Have you smoked in the last 12 months? | |
| What illness(es) do/did you have? | |
| What parts of the body are/were affected? | |
| When was it / they diagnosed? | |
| What are/were your symptoms? | |
| What treatment/surgery have you received so far and when? | |
| What is your current treatment? Please give the name and dosage of any medication you are taking. | |
| Is any further treatment/surgery planned? | |
| Please give the name and address of your specialist and how often you attend check-ups. | |
| Have you had any tests recently which monitor your illness? If yes, please give the name and the result. | |
| Are you able to; a) work full-time, and/or b) lead a normal life? If not, please give details? | |
| Any other information which we should declare to the insurers? | |

Please return this form with the general Life Insurance Questionnaire