

Back Pain Supplementary Statement – This questionnaire should be completed by the person to be insured.

Full name of the person to be insured: _____

Date of Birth & Age: _____

1. Do you know the exact diagnosis stated by your physician (i.e. herniated intervertebral disc; spondylolisthesis; kyphosis, etc)?

2. If not, please describe the location of the pain (i.e. neck, upper back, lower back, etc.).

3. Have investigations such as X-rays or MRI been performed?

☐ Yes

☐ No

If "yes", please provide details.

Date	Details (type of test and result)

4. When did the symptoms first occur?

Are you now fully recovered?

☐ Yes

☐ No

5. How frequently do the symptoms occur (i.e. once every month, twice a year, etc.)? **And when you last had them?**

6. Have you been absent from work due to back pain?

☐ Yes

☐ No

If "Yes", please provide details.

Date	Details
From to	
From to	
From to	

7. Please provide the name and address of your physician.

I hereby declare that the above statements are true and complete and agree that this supplementary statement together with the proposal dated _____ shall form part of the contract between me and the Company.

Date and signature of the person to be insured