IndiaFirstLife

GYNAECOLOGICAL DISORDER QUESTIONNAIRE

[To be filled by the medical examiner]

Application No: _____

Full Name of life to be assured: _____

1. Please state the precise diagnosis

_____

2. Please describe the symptoms :
   a) Nature of Symptoms: _____
   b) First Occurrence: _____
   c) Frequency of symptoms in last one year: _____
   d) Last Occurrence: _____
3. Please provide details of treatment and investigation done :
   a) Current Treatment: _____
   b) In the past: _____
   c) Investigation Done: _____
4. Have you had an operation for this condition or is Operation being considered Yes ☐ No ☐
   If yes please state the date and submit copies of all hospital records and discharge summary
5. Have you undergone PAP smear test Yes ☐ No ☐
   If yes please provide the date and results of the test.

Date	Results

6. Have you lost significant time (more than 1 week) off work with this condition? Yes ☐ No ☐
7. Are you still being followed-up? Yes ☐ No ☐
   If yes a) How often do you attend for Follow Up: _____
   b) When were you last consultation: _____

Hysterectomy

8. Have you suggested/ undergone Hysterectomy Yes ☐ No ☐
   If yes a) State reason for hysterectomy: _____
   b) When was it performed: _____
9. Did you received / suggested any other treatment apart from hysterectomy Yes ☐ No ☐
   (If yes, please mention the same in detail)

_____

10. Have there been any complications following Hysterectomy. (If yes, please explain in detail) Yes ☐ No ☐

_____

11. Have you lost significant time (> 1week) off work with this condition? Yes ☐ No ☐
12. Are you still being followed-up
    If yes a) How often do you attend for follow-up: _____
    b) When was your last consultation: _____

13. Please provide complete Name and Address of your treating physician.

14. Please provide any additional information, which you feel, will be helpful in processing Your application.

I hereby agree that the forgoing questions and answers shall form part of the proposal for insurance made by me to the Company.

Signature of the life to be assured/Proposer

Signature of Medica l Examiner with Code no.

Date:

Place:

Date:

Place: