



# UNDERWRITING QUESTIONS

PLEASE ANSWER "YES" OR "NO" FOR EVERY QUESTION

Item No:	Do you, or all your dependants, have or have you had, or plan to have any treatment, advice, investigations or management for any of the following conditions or diseases in the past or in the future:-	APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke(C.V.A.), or peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Obstructive Lung Disease (Asthma, Emphysema or C.O.A.D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Diabetes (Insulin or non-insulin dependant diabetes mellitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Hypo or Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Arthritis, I.e. Osteo, Rheumatoid Arthritis or Gout related musculoskeletal conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Gastro-oesophageal reflux disease (GORD/Heartburn) or Stomach or Duodenal Ulcers (please circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Immune Deficiency States I.e. HIV/AIDS, Immunoglobulin deficiencies  * Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership (contract) number we require you to please fax confirmation of your HIV/Aids status to our HIV/Aids Department on (031) 580 0484. For more information on the Aid for Aids Programme members may also call Aid for Aids on 0860 100 646. Note that all information supplied will be treated as confidential. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Anaemia or abnormalities of clotting mechanism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Hormone Replacement Therapy, Endometriosis or Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Depression and/or anxiety disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Glaucoma or cataracts (please circle where applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Parkinson's disease or Multiple sclerosis (please circle where applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Hyperplasia of prostate ( BPH) or prostatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Urinary Tract infection or calculi (stones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Back or neck related condition (Lumbago, sciatica, injury, spasm etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Are you, or any of your dependants pregnant, if so how many weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Have you, or any of your dependants had any surgical procedure during the past 12 months or are you or any of your dependants planning a surgical procedure within the following 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Are you, or any of your dependants on any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical aid claim within the next 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE PROVIDE DETAILS BELOW IF YOU HAVE ANSWERED "YES" TO ANY OF THE UNDERWRITING QUESTIONS

Item No. \_\_\_\_\_ Name: \_\_\_\_\_  
 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

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 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

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 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
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 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

**NB Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and /or membership terminated.**