

Form Med 04 - Medical Conditions Supplementary Questionnaire
Back Trouble (including Whiplash, Sciatica/Slipped Disc)

Full Name: _____ **Date of Birth:** _____

Please remember that failure to answer the relevant questions fully may affect the underwriting decision and therefore terms offered may be amended or withdrawn.

1. What is the exact diagnosis, if known?

2. Has it kept you off work or affected your lifestyle?
Yes No If **yes**, please give details including time off work, if any:

3. Please state frequency and severity of symptoms.

4. Date last suffered any symptoms.

5. What treatment have you received in the past?

6. What treatment are you currently receiving?

7. Has an operation been carried out or considered?
Yes No If **yes**, please give details:

8. Have you been prescribed any drugs in the past?
(Please give name of drug and dosage)

9. Are you currently taking any drugs for the condition?
(Please give name of drug and dosage)

10. Have you ever, or do you intend to consult a chiropractor, physiotherapist or acupuncturist?
Yes No If **yes**, please give details:

Note:
Please ensure your answers given in this questionnaire are, to the best of your knowledge, true and complete and that no information is withheld which may influence the underwriting of the application(s) for Life Assurance, Critical Illness cover, Income or Mortgage Payment Protection. Failure to disclose any material facts known may affect the terms offered. If you fail to provide any of this information or if you mis-state any information this could mean that the terms offered may be amended or withdrawn. If you are uncertain as to the relevance of any such information please disclose it anyway.