Form Med 10 - Medical Conditions Supplementary Questionnaire

Gynaecological Disorder

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answer the relevant questions fully may affect the underwriting decision and therefore terms offered may be amended or withdrawn.

Please complete the relevant section(s):

Abnormal Smears

1. Date of abnormal smear:	
2. Treatment given:	
3. Exact diagnosis, if known:	
4. Date and result of latest smear:	
5. Have you been asked to attend for a further smear? If so, when?	

Hysterectomy

1. Reason for and date of operation:	
2. Did you receive any other treatment? (ie: radiotherapy, drugs) If so, please give details including dates	
3. Are you still attending for check-ups? If not, what was the date and result of the last one?	
4. For how long have you been symptom free?	

Other gynaecological disorders
(ie: HRT, Endometriosis, Cervical Erosion)

1. Nature of disorder and date diagnosed	
2. Treatment, if applicable	
3. For how long have you been symptom free?	

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any of this information or if you mis-state any information this could mean that the terms offered may be amended or withdrawn.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.