Form Med 12 - Medical Conditions Supplementary Questionnaire

Migraine/Headaches

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answer the relevant questions fully may affect the underwriting decision and therefore terms offered may be amended or withdrawn.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. When did you first suffer from headaches/migraines?

2. How often do you suffer attacks?

3. What treatment have you taken in the past?

4. What treatment are you taking now?

5. Please advise, with dates and results, details of any investigation or tests which have been carried out.

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any of this information or if you mis-state any information this could mean that the terms offered may be amended or withdrawn.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