GENERALI

Proposal/*Policy No.:*

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GENERAL MEDICAL QUESTIONNAIRE

Name :_____

1. Please state the precise diagnosis, or nature of the condition that you are suffering from and attach acopy of any medical reports if available.

2. When was the condition diagnosed or when did you first experience symptoms?

3. Please describe your symptoms:

4. How often do you typically experience symptoms?

5. Is the frequency of symptoms becoming? ☐ more frequent ☐ less frequent ☐ unchanged

6. Are you aware of anything that precipitates your symptoms? ☐ Yes ☐ No
   If yes, please provide details:

7. When did you last experience symptoms? / /

8. Do you currently take any medication for this condition? ☐ Yes ☐ No
   If yes, please provide details:

Name of medication	Dose	Frequency

9. Other than already stated above, have you taken any other medication or had any other treatment in the past for this condition? ☐ Yes ☐ No
   If yes, please provide details:

Name of medication or treatment	Dose	Frequency	Date last taken

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200601003992 (723739-W)
8th Floor, Chulan Tower, No.3 Jalan Conlay, 50450 Kuala Lumpur
Telephone: 03-2117 6688 Fax: 03-2117 3698 Customer Service: 1300 88 1616 Medical Card: 1300 80 0020
Email: customer.service.life@generali.com.my Website: www.generali.com.my

10. Have you ever had any tests or investigations for this condition? ☐Yes ☐No
If yes, please provide details:

Name of medication or treatment	Dose	Frequency	Date last taken

11. Have you ever been admitted to hospital or required emergency treatment for this condition? ☐Yes ☐No
If yes, please provide details:

Name of doctor, hospital or clinic	Address	Dates

12. Has any further treatment or investigation been discussed or contemplated? ☐Yes ☐No
If yes, please provide details:

13. Please provide details regarding the doctors and/or specialists you see in relation to this condition:Name of doctor, hospital or clinic Address

Name of doctor, hospital or clinic	Address	Date of last consult

14. Have you ever taken time off work with this condition? ☐Yes ☐No
If yes, please provide dates and durations:

15. Have your working duties ever been affected or restricted in any way? ☐Yes ☐No
If yes, please provide details including dates and durations:

16. Please provide any additional information that you feel is important:

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

		/ /
Name	Signature	Date

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