UV INSURANCE

NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

RHUMATISM, ARTHRITIS OR GOUT QUESTIONNAIRE

1. **What is the exact diagnosis of your attending physician? (Osteoarthritis, Rheumatoid Arthritis, Ankylosing Spondylitis, etc.)**

   _____

2. **Is the disease:** Benign ☐ Moderate ☐ Severe ☐

3. **Which of your joints are affected? (Hands, wrists, knees etc.)** _____

   _____

4. **Symptoms:** ☐ High fever ☐ Redness of the joint(s) affected
   ☐ Stiffness ☐ Swelling of the joint(s) affected

5. **Have you had medications prescribed:** ☐ Yes ☐ No **If yes**, please complete the following table:

Name of medication	Dosage	Frequency	Date of last used

6. **How frequently do symptoms occur?** _____

7. **Have you ever been bed ridden?** Yes ☐ No ☐

   If yes, provide the date and duration: _____

8. **Have you ever been retained at home?** Yes ☐ No ☐

   If yes, provide the date and duration: _____

9. **Have you ever been hospitalized?** Yes ☐ No ☐ **If yes**, provide the date, duration and location:

   _____

10. **Have you taken time off work?** Yes ☐ No ☐ **If yes**, details :_____

    Date : from: ____/____/____ (D M Y) to: ____/____/____ (D M Y) **If more than once :** from: ____/____/____ (D M Y) to: ____/____/____ (D M Y)

11. **Are your activities restricted and at what percentage? Please provide the complete details:**

    _____

12. **Do you have any associated disorder?** Yes ☐ No ☐ **If yes**, provide the complete details: _____

    _____

13. **Name(s) and address(es) of the consulted physician(s):** _____

    _____

    _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____

SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____

WITNESS **DATE**