UV INSURANCE

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

MUSCULOSKELETAL DISORDER QUESTIONNAIRE

1. **Date the injury occured**: _____/_____/_____ (D / M / Y)
2. **Please provide the precise location of the pain or injury:** _____
3. **How did the injury occur?** _____
4. **How frequently do symptoms occur?** _____
5. **Diagnosis:** _____
6. **Have you had medications prescribed:** ☐ **Yes** ☐ **No** **If yes**, please complete the following table:

Name of medication	Dosage	Frequency	Date of last used

7. **Have you ever had any chiropractic treatments, physiotherapy osteopathy, etc.?** ☐ **Yes** ☐ **No**
If yes, please complete the following table:

Type of treatment	Name of practitioner or clinic	Address	Frequency	Date of last consultation

8. **Did the injury require the necessity to use any orthopedic equipment?** ☐ **Yes** ☐ **No**
If yes, provide complete details: _____
9. **Have you had any surgery (ies)?** ☐ **Yes** ☐ **No** **If yes**, provide complete details:_____
Date: _____/_____/_____ (D / M / Y) Name and address of the hospital: _____
10. **Time off work:** From _____/_____/_____ To _____/_____/_____ (D / M / Y)
If more than once: From _____/_____/_____ To _____/_____/_____ (D / M / Y)
11. **Have you fully recovered?** ☐ **Yes** ☐ **No** **If yes**, since when: _____/_____/_____ (D / M / Y)
If no, provide complete details: _____
12. **Do you have any permanent physical damage:** _____
13. **Name(s) and address(es) of the doctor(s) consulted:** _____
14. **Is there any other medical consultations or treatments foreseen in the future:** _____

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_____ **SIGNATURE OF THE PROPOSED INSURED**

X_____ **SIGNATURE OF THE POLICY OWNER**

X_____ **WITNESS**

_____ **DATE**

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