# Apply

Quote number

(Mandatory Field) initial application

partners life

## Mental Health, Sleep and Chronic Conditions Questionnaire

### 1.0 Life assured's details

Title Mr ☐ Mrs ☐ Miss ☐ Other ☐

First name

Middle name(s)

Surname

Gender Male ☐ Female ☐

Date of birth

### 2.0 Personal statement

**a) What is the condition?**

**b) When were you first diagnosed with this condition?**

Date

**c) Give details of your specialist where applicable. (i.e. psychiatrist)**

**d) What treatment or medication have you most recently been prescribed?**

**e) If you no longer require treatment or medication for this condition when did you stop?**

Date

**f) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.**

**g) Please provide details of any tests or investigations you have undergone for this condition including dates, the name of the medical facility and the outcome.**

Date Facility

| Test or investigation | Outcome |
|---|---|
| | |

**h) Provide details of any impact this condition has had on your work.**

**i) How frequently do you experience symptoms?**

**j) When did you last experience symptoms?**

Date

**k) If you have been hospitalised for this condition please give date, name of hospital, reason and outcome.**

Date | Facility

| Reason | Outcome |
|---|---|
| | |

**l) Describe any long-term or permanent disability you suffer from as a result of this condition.**

**m) Have you ever had suicidal thoughts or made a suicide attempt?** Yes ☐ No ☐

## 3.0 Declaration

I/we declare and agree that the information provided in this Mental Health, Sleep and Chronic Conditions Questionnaire, whether in my/our handwriting or not, is true and complete and I/we have not withheld or misstated any material fact.

Life assured to acknowledge the above declaration.

Signature of life assured | Date