

## MENTAL HEALTH QUESTIONNAIRE

(To be completed by the life insured)

### 1. Life insured's details

Policy no. \_\_\_\_\_ Identity no. \_\_\_\_\_

Name of insured \_\_\_\_\_

Please indicate which of the following mental health condition/s you have had or currently experience:

Anxiety including generalised anxiety, panic or phobic disorder	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Eating disorder including anorexia nervosa or bulimia	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Depression including major depression or dysthymia	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Bipolar disorder or manic depressive illness	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Alcohol or other substance abuse or addiction	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Post-traumatic stress	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Schizophrenia or any other psychotic disorder	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Stress, sleeplessness, chronic tiredness	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Other	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES, please describe \_\_\_\_\_

1.1 When did the symptoms of your condition first occur? State month, year and duration

\_\_\_\_\_

1.2 What were the symptoms?

a. Physical, e.g. weight loss, loss of appetite, fast pulse, stomach trouble

\_\_\_\_\_

b. Mental, e.g. insomnia, anxiety, worry, depression

\_\_\_\_\_

1.3 When did the symptoms last occur?

D	D	M	M	Y	Y	Y	Y
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1.4 In your opinion, what caused the condition and relapses?

\_\_\_\_\_

1.5 What was the final diagnosis made by your attending doctor?

\_\_\_\_\_

1.6 What treatment/type of medication are you currently taking? State dosage of medication and type of other treatment(s) if applicable

\_\_\_\_\_

\_\_\_\_\_

1.7 What treatment/medication did you receive in the past? State dosage and type of medication and type of other treatment(s) if applicable

\_\_\_\_\_

\_\_\_\_\_

1.8 For how long have you been on treatment/medication?

\_\_\_\_\_

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1.9 Have you ever been absent from work as a result of your condition?

YES  NO

If YES, give dates and for how long? \_\_\_\_\_

1.10 Have you ever been hospitalised?

YES  NO

If YES, give date and name of hospital

D	D	M	M	Y	Y	Y	Y
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1.11 Is there anyone in your family who suffers from a nervous or mental condition?

YES  NO

If YES, give details

\_\_\_\_\_

1.12 Have you ever attempted suicide?

YES  NO

If YES, give details

\_\_\_\_\_

1.13 Have you undergone any special examinations, tests or investigations?

YES  NO

If YES, give details and supply the name of the doctor consulted \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1.14 Is your condition:

controlled  resolved

Provide details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1.15 Give the name(s) and address(es) of the doctor(s) and other specialists who have treated you

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\_\_\_\_\_

Initials



## 2. Declaration by life insured

I declare that the statements above are true and complete and shall form part of my application for insurance and I declare that the statements together with my application shall be the basis of the contract between me and Hollard Life.

I authorise Hollard Life to approach any doctor or medical institution to confirm the details of my medical history.

### Please take note of the following Hollard disclosures

#### Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

#### Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as, but not limited to, directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature  
(life insured)

\_\_\_\_\_

Date

D	D	M	M	Y	Y	Y	Y
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