

MAS, FREEPOST 884, PO Box 13042, Johnsonville, Wellington.
Phone 0800 800 627. Facsimile (04) 477 0109.

General health questionnaire

i) Name of condition	<input type="text"/>	
ii) Location of condition (e.g. left eye)	<input type="text"/>	
iii) Date of first symptoms	<input type="text" value="D D / M M / Y Y"/>	
iv) Date of last symptoms	<input type="text" value="D D / M M / Y Y"/>	
v) Name(s) of doctors or health professionals consulted including date(s)	<input type="text"/> <input type="text" value="D D / M M / Y Y"/> <input type="text" value="D D / M M / Y Y"/>	
vi) Have you ever been hospitalised, attended a clinic or had time off work or study as a result of this condition? <i>* If yes, please provide details at x) below</i>	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
vii) Have there ever been any subsequent problems, impairments or after-effects from this condition? <i>* If yes, please provide details at x) below</i>	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
viii) Have you received or are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? <i>* If yes, please provide details at x) below</i>	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
ix) Have you ever had any recurrence of this condition? <i>* If yes, please provide details at x) below</i>	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
x) Please provide full details if you have answered yes to questions vi), vii), viii) or ix) above.	<div style="border: 1px solid black; height: 200px; width: 100%;"></div>	

I acknowledge that the answers I have provided above are true and complete and form part of my application under policy

Member Name ☐

(*Please type your name and tick the check box to verify the above information)