

Insurance application form

Issued 23 October 2017

Suncorp Portfolio Services Limited (Trustee)
ABN 61 063 427 958, AFSL 237905, RSE L0002059

Adviser ID
(if applicable)

Use this form to apply for insurance cover or to apply for additional/increase to existing cover

Tips to help you complete this form

- Use a blue or black pen and write in CAPITAL letters
- Use an 'x' to mark answer boxes
- Complete all sections of the form and sign and date on the last page

Have any questions?

If you'd like help completing this form, or if you have any questions, just call 13 11 55.

Your duty of disclosure

Before a contract of life insurance is entered into with the insurer, the Trustee has a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that it knows, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

This duty of disclosure continues to apply until the contract is entered into. It also applies when the insurer extends, varies or reinstates a contract of life insurance.

This duty, however, doesn't require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that's of common knowledge
- that the insurer knows, or in the ordinary course of their business, ought to know
- as to which compliance with the duty is waived by the insurer.

As the Insured Person you have the same duty of disclosure and it is a condition of your membership to discharge that duty.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it.

If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

The insurer may elect not to avoid the contract but to vary it by:

- reducing the sum insured in accordance with a formula that takes into account the premium that would have been payable if you had complied with your duty of disclosure; or
- placing the insurer in the position in which the insurer would have been in if you had complied with your duty of disclosure.

The options to vary the contract are available to the insurer while the contract remains in force.

Where the contract provides life cover, the insurer may only apply

- above and must do so within 3 years of entering into the contract.

As the contract is for insurance of your life as the insured person, any failure by you to provide information about a matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to give you insurance and, if so, on what terms, may be treated as a failure by us, as the policy owner, to comply with our duty of disclosure.

Personal details

Account number*	<input type="text"/>
Title*	<input type="text"/> Single <input type="checkbox"/> Married <input type="checkbox"/> De-facto <input type="checkbox"/> Gender* Male <input type="checkbox"/> Female <input type="checkbox"/>
Last name*	<input type="text"/>
Given name(s)*	<input type="text"/>
Date of birth*	<input type="text"/>
Daytime phone number	<input type="text"/> Mobile phone number* <input type="text"/>
Email address*	<input type="text"/>

*mandatory field

Insurance cover

Under the MySuper regulations, employees receiving a Suncorp Brighter Super for business account must be provided with a minimum level of Life and Total and Permanent Disablement (TPD) Insurance. New members joining Suncorp Brighter Super for business will be automatically provided the greater of the employer plan default (if applicable) or MySuper Trustee minimum. Members are free to keep the default level of cover, choose their own level of cover or to opt out of insurance. More information can be found in the Suncorp Brighter Super PDS or Product Guide. This application form is not required if you wish to retain your current level of cover.

1. Please select one of the following options:

- I am applying for an increase which is a fixed amount
- I am applying for an increase which varies with my salary in line with my existing employer salary-based design
- I am applying for new cover
- I am applying for employer default cover (if eligible)

2. If you want new cover please select one of the following options and answer ALL questions below:

Life cover only Amount of cover
(in addition to any existing benefit) \$

or

Life and TPD cover Amount of Life cover
(in addition to any existing benefit) \$

Amount of TPD cover
(in addition to any existing benefit) \$

Note: When applying for Life and TPD, the TPD cover amount can't exceed the Life cover amount.

Income Protection Amount of cover (this cannot be greater than 75% of your salary) \$ pa

Amount of cover (up to 10% of salary for super contributions)^ \$ pa

Waiting period 30 days 60 days 90 days

Benefit period 2 years until age 65

^ This option isn't available if your superannuation guarantee contributions are included in the salary provided below.

How to complete the rest of this application

First, you'll need to complete the 'Occupational details' section, then:

You can complete 'Part A – Short personal health statement' if the following applies to you	You must complete 'Part B – Full personal health statement' if the following applies to you
<p>You're under age 55 and applying for sums insured up to \$1,000,000 (including any existing cover) for Life only or Life and TPD.</p> <p>You can't complete 'Part A – Short personal health statement' if you're applying for Income Protection. Please complete 'Part B – Full personal health statement'.</p> <p>Please note if you answer "Yes" to any of the questions in 'Part A – Short personal health statement', you'll also need to complete 'Part B – Full personal health statement'.</p>	<p>You're age 55 and over or</p> <ul style="list-style-type: none"> would like sums insured over \$1,000,000 (including any existing cover) for Life only or Life and TPD and/or you're applying for Income Protection.

Occupational details

1. Please refer to the Suncorp Brighter Super insurance premium rates guide on our website at suncorp.com.au for a list of occupations.

Occupation

2. Industry in which you're employed

3. Occupation category (your adviser can assist with this). If you are unsure on your occupation category, please refer to the insurance section in the Suncorp Brighter Super Product Guide.

- Professional
- White Collar
- Light Blue Collar/Grey
- Skilled Blue Collar
- Heavy Blue Collar
- Hazardous

4. Hours worked per week

5. Basis of employment:

Permanent

Casual

Contract

Self-employed

6. What has been your insurable income over the past 12 months?
(Please refer to the Suncorp Brighter Super Product Guide for the definition of 'salary')

Employees

7. What has been your annual salary over the past 12 months?
(Please refer to the Suncorp Brighter Super Product Guide for the definition of 'salary')

8. Please complete the following if you're applying for TPD and/or Income protection.

Name of employer

Street address

Suburb/Town

State Postcode

9. Are you self employed? Yes No

10. If 'yes', by own company? Yes No

11. Do you have employees. If so, how many?

12. How many weeks do you work per year?

13. What are the principle duties of your occupation and where do you perform these duties?

Duties (eg office, manual, site supervision, selling, etc)	Percentage of time (%)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Location (eg office, on site, at home, driving, etc)	Percentage of time (%)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

14. Do you intend to change your occupation or duties, employment status or take extended leave within the next 12 months? Yes No

15. If 'yes', details of change Date of change

Personal Members only:

16. Have you or any business with which you have been associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? Yes No

17. If 'yes', please provide details.

a.. Date declared bankrupt Date of Discharge

b. Original amount owed

PART A – Short personal health statement

1. Please provide the following details:

Height _____ cm or _____ feet/inches
 Weight _____ kg or _____ stone/pounds

Important information

If you answer “Yes” to any of the questions in the short personal health statement below, please DO NOT continue completing this section. Instead, please complete Part B - Full personal health statement

2. Have you smoked tobacco or any other substance in the last 12 months? Yes No
3. Do you engage in any hazardous activities, pursuits or occupational duties, such as but not limited to motorised sports, scuba diving below 40 metres or aviation (other than as a fare paying passenger on a licensed public service (eg Qantas))? Yes No
4. Do you have any definite plans to travel or reside overseas in the future? (Holidays less than 4 weeks don't need to be disclosed) Yes No
5. Have you ever suffered symptoms of, or had, or been told you have, or received or are contemplating any advice or treatment for:
- i) Muscular skeletal disorders (eg back, joint), arthritis, loss of limb or paralysis Yes No
 - ii) Impairment of sight or hearing (not including long or short sightedness) Yes No
 - iii) Mental or nervous disorder including stress, anxiety, depression or neurological condition Yes No
 - iv) Cancer or tumour of any type Yes No
 - v) Diabetes or liver disease including hepatitis Yes No
 - vi) High blood pressure, high cholesterol, chest pain, heart complaint or stroke Yes No
 - vii) Disorders and or disease of the kidney, bladder, bowel or stomach? Yes No
6. Have you ever:
- i) Suffered from AIDS or been infected with the HIV virus, or Yes No
 - ii) Used intravenous drugs or had sexual activity with someone you know or suspect to be HIV positive, or Yes No
 - iii) Engaged in male to male anal sexual activity? Yes No
7. To the best of your knowledge, have two or more members of your immediate family, ie parents, brothers or sisters (living or deceased) suffered from any hereditary disease before age 60? Yes No
8. Does your alcohol consumption exceed more than 20 standard drinks per week? Yes No

If you answered “No” to all of the above questions, please go straight to the ‘Signature of insured person’ section on the last page of this application.

PART B – Full personal health statement

Insurance history (must be completed)

1. Do you have with us or any other company, or are you currently applying for, any type of life, superannuation, sickness, accident, trauma, lump sum disablement or disability insurance? Yes No
- If ‘yes’, please provide:

Name of company	Type of insurance	Insured benefit	Date commenced	Is policy to be discontinued/replaced?
		\$	/ /	Yes* <input type="checkbox"/> No <input type="checkbox"/>
		\$	/ /	Yes* <input type="checkbox"/> No <input type="checkbox"/>

*If you've indicated that it's your intention to replace insurance you currently have with the cover you're now applying for, the replacement cover under any policy we issue will only start when the insurance which is to be replaced is cancelled.

2. Has any application for insurance ever been refused, postponed, accepted with an increased insurance fee or on modified terms? Yes No
- If ‘yes’, please provide details:

3. Are you claiming or have you ever claimed benefits from any source eg an insurance policy, workers compensation, social security (including unemployment benefits), veterans affairs, sickness benefits, invalid pension, third party, etc? Yes No
- If ‘yes’, please provide:

Date	Source	Reason	Has the claim been settled/ benefits ceased?	Date ceased
/ /			Yes <input type="checkbox"/> No <input type="checkbox"/>	/ /
/ /			Yes <input type="checkbox"/> No <input type="checkbox"/>	/ /

Residence and travel (must be completed)

1. Were you born in Australia? Yes No
 If 'yes', please go straight to question 3
2. Are you an Australian citizen or do you hold an Australian Permanent resident visa? Yes No
 How long have you lived in Australia? Country of birth Visa type
3. Do you travel overseas in your job? Yes No
 Countries Purpose
 Duration Frequency
4. Do you have definite plans to live or travel overseas in the future? Yes No
 If 'yes', please advise Date leaving / / / / Date returning / / / /
 Countries to be visited Reason for trip

Medical history (must be completed, except when a medical examination is required)

1. What is your height and weight?
 Height _____ cm or _____ feet/inches
 Weight _____ kg or _____ stone/pounds
2. Are you left handed or right handed? Left Right
3. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- a. Heart attack, angina, chest pain, stroke, hypertension (high blood pressure) or high cholesterol readings? Yes No
 - b. Asthma, bronchitis, emphysema? Yes No
 - c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder? Yes No
 - d. Epilepsy, fainting attacks or fits of any kind? Yes No
 - e. Recurrent indigestion, ulcer, Hepatitis (A, B, C or D)? Yes No
 - f. Cancer, tumour, sunspot, skin cancer, lump or growth of any kind or breast lumps (even if you have not seen a doctor)? Yes No
 - g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses) Yes No
 - h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs? Yes No
 - i. Arthritis, gout, fibromyalgia, osteoporosis, tendonitis, tenosynovitis, overuse syndrome or any regional pain syndrome or chronic fatigue?... Yes No
 - j. Diabetes or abnormal blood sugar? Yes No
 - k. Psoriasis, eczema or any other disorder of the skin, or any allergic or chemical sensitivity reaction? Yes No

If you answered 'yes' to any of the conditions above, please also complete a Special health questionnaire (on pages 10 to 13) for each condition.

4. Other than those conditions stated in question 3, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- l. Heart murmur or any other heart or blood vessel disorder? Yes No
 - m. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? Yes No
 - n. Tuberculosis or any other lung or respiratory system disorder? Yes No
 - o. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? Yes No
 - p. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancreas? . Yes No
 - q. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? Yes No
 - r. Sleep apnoea or any sleeping disorder? Yes No
 - s. Thyroid disorder or any other glandular disorder? Yes No
 - t. Any sickness, injury or physical impairment not previously mentioned? Yes No
5. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)? Yes No
6. Have you ever had or are you considering having a genetic test where you received (or are currently awaiting) an individual result? Yes No
7. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation? Yes No

Question no. Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

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Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced / / Time off work Degree of recovery (%)

Date of last symptoms / / Treatment received

Full name and address of doctor or hospital

State Postcode

Habits (must be completed, except when a medical examination is required)

1. Have you ever smoked tobacco or any other substance, or, in the last 12 months, used any nicotine replacement therapy product? Yes No

If 'yes', type (eg cigarettes, gum, patches)? Daily quantity?

How many years? Date ceased (if applicable) / /

Other

2. Do you drink alcohol? Yes No

If 'yes', please advise number of standard drinks per week? Standard drink = 30 ml (1 nip) spirits, 100 ml (1 glass) wine, 60 ml (1 serve) sherry or port, 285ml (middy/half pint) full strength beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? Yes No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol? Yes No

If you answered 'yes' to question 3 or 4, please provide details in the following table

Question no.	Date from	Date to	Type of usage (alcohol, heroin etc)	Name and address of doctor who has full details
	/ /	/ /		
	/ /	/ /		

Motor sports

- a. Type (car, bike etc)
- b. Events (speedway, off road etc)
- c. How long have you been doing this?
- d. How often do you do this?
- e. Are you professional or amateur?

f.

Category (eg touring cars)	Class (eg AA/D)	Vehicle & type of fuel	Engine capacity	No. of vehicles in event	Max speed km/hour
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- g. Do you intend to change the scope of your license/participation?..... Yes No
 If 'yes', please provide details.

Flying – power-driven aircraft or conventional glider

- a. What type of flying do you do (private, agricultural, ultralight etc)?
- b. Total number of hours flown as a pilot? Hrs
 Number of hours in the past 12 months? Fixed Wing Hrs Helicopter Hrs
- c. Number of hours expected in the next year? Fixed Wing Hrs Helicopter Hrs
- a. Geographical location
- b. What class license do you hold?
- c. Do you intend to change the scope of your license?..... Yes No
 If 'yes', please provide details.

Abseiling, caving, mountaineering, rock climbing

- a. Activity
- b. How long have you been doing this?
- c. How often do you do this?
- d. Geographical location
- e. Maximum altitude/depth
- f. Equipment used
- g. Maximum grade of climb
- h. Type (top roping etc)

Other activity

- a. Describe activity
- b. What are your qualifications for this?
- c. How long have you been doing this?
- d. How often do you do this?
- e. Geographical location
- f. Are you professional or amateur?

If you answered 'yes' to any of the questions on page 5, please also complete the relevant special health questionnaire for each condition.

Special health questionnaires

Skin Lesion/Skin Cancer/Sun Spot

1. How many skin lesions, skin cancers or sun spots have you had treated?

2. Please provide details of each of the above in the table below. If more than 3, provide details on a separate page.

	Lesion 1	Lesion 2	Lesion 3
a) Where on the body was it located: eg arm, nose, scalp.			
b) Was the lesion benign or malignant?			
c) What was the diagnosis? ie the name advised by your doctor eg melanoma, BCC, keratosis etc.			
d) What was the date of diagnosis, biopsy, or treatment?			
e) How was it treated?* See examples of treatment types below.			

***Examples of treatment types:** Excised (surgically removed), curettage (removal with a scraping instrument), cryotherapy (freezing off), diathermy (burning off), topical cream eg Efudix/Aldara or photodynamic therapy.

3. Have you been advised to have regular skin checks? Yes No

If 'yes', please advise by whom and the frequency.

4. What was the date and result of your last skin check and the name and address of the doctor or clinic consulted?

Name & address

Date | d | d | / | m | m | / | y | y | y | y |

5. Has any further follow-up or treatment been recommended? Yes No

If 'yes', please provide details.

6. Do you have or can you obtain a copy of any pathology reports which relate to the skin lesion(s)/cancer(s) or sun spot(s) treated? Yes No

If 'yes', please attach a copy to this application.

7. Does your regular doctor, skin specialist or skin clinic have details regarding the lesion(s)/cancer(s) or sun spot(s)? Yes No

If 'yes', please indicate which one and provide the name and address if it's not your usual doctor.

If 'no', please provide the name and address of the doctor who has full details.

Name & address

8. Do you have any skin lesions for which you are considering consulting a doctor or seeking medical advice or treatment? Yes No

If 'yes', please provide details.

Hypertension (High Blood Pressure)

1. When were you first diagnosed with hypertension? / /

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition?.....Yes No

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two readings/tests, including dates and any change to your treatment

Date	Reading (If unsure, answer 'unsure')	If treatment was changed, give details
/ /		
/ /		

5. Have you had an electrocardiogram (ECG), Blood Pressure monitor or any other heart test?.....Yes No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Do you have any complications as a result of hypertension?.....Yes No

If 'yes', please provide details

7. Does your regular doctor have details of this condition?.....Yes No

If 'no', please provide the name and address of the doctor who has full details

High Cholesterol

1. When were you first diagnosed with high cholesterol/triglycerides? / /

2. What was your pre-treatment level?

Date	Reading (If unsure, answer 'unsure')
/ /	

3. Have you taken regular or occasional medication for this condition?.....Yes No

If 'yes', please advise commencement date, type, dosage and frequency.

4. Please provide details of your last two cholesterol test results, including dates and any change to your treatment

Date	Result (If unsure, answer 'unsure')	If treatment was changed, give details
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	
/ /	Cholesterol	
	HDL	
	LDL	
	Triglycerides	

5. Have you had an electrocardiogram (ECG), blood pressure monitor or any other heart test?.....Yes No

If 'yes', please advise the date, referring doctor's details, type of test and result, if known.

6. Does your regular doctor have details of this condition?.....Yes No

If 'no', please provide the name and address of the doctor who has full details

Asthma

1. Date asthma first diagnosed / /
2. How often do you experience symptoms? eg wheezing, breathlessness, chest tightness.
3. When did you last experience symptoms?
 / /
4. Are you woken during the night with symptoms?..... Yes No
If 'yes', how often and date of last occurrence.
5. Have you ever been off work due to your asthma? Yes No
If 'yes', please advise when and for how long.
6. What is your current treatment? Include type of medication and dosage.
7. Have you ever required use of oral steroids? Yes No
If 'yes', please advise when and for how long.
8. Have you ever been in hospital or received emergency treatment for asthma? Yes No
If 'yes', please advise when, for how long and where.
9. Do you ever measure your peak flow? Yes No
If 'yes', please advise your highest and lowest readings in the past 6 months.
10. Have you ever consulted a specialist for this condition? Yes No
If 'yes', please advise name and address of doctor and date of last consultation.
11. Does your regular doctor have details of this condition? Yes No
If 'no', please provide name and address of doctor who has full details.
12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

Anxiety/Depression/Nervous Disorder

1. Nature of condition and underlying cause.
2. Describe your symptoms.
3. Date symptoms commenced..... / /
- i) Are you still experiencing symptoms? Yes No
- ii) If 'no', when did you last experience symptoms?
 / /
4. Have you had any recurrence of this condition? Yes No
If 'yes', please advise when and how many times.
5. Have you taken regular or occasional medication for this condition? Yes No
If 'yes', please advise type, dosage and frequency.
6. Are you still taking this medication? Yes No
If 'no', please advise date ceased / /
7. Have you had any other treatment (eg, counselling, hospitalisation, ECT)?..... Yes No
If 'yes', please advise type, dates, hospital and name and address of treating doctor.
8. Have you ever been off work or had your normal daily activities restricted in any way due to this condition?..... Yes No
If 'yes', please advise when and for how long.
9. Have you any ongoing effects or restriction in your activities of any kind? Yes No
If 'yes', please provide details.
10. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? Yes No
If 'yes', please advise dates and name and address of all persons consulted.
11. Please provide details of your most recent visit for this condition. Include date, name and address of the doctor or health professional consulted.
12. Does your regular doctor have details of this condition? Yes No
If 'no', please provide name and address of doctor who has full details.

Back/Neck

- Area of spine affected? Neck, upper or lower back?
- Date of first symptoms
- What was the cause?
- Have you had any diagnostic investigations eg CT Scans, x-rays etc? Yes No
 If 'yes', please provide details of test(s), result(s) and date(s).
- Are you still experiencing symptoms? Yes No
 If 'no', please provide date of last experienced symptoms?
- How often do/did you have symptoms?
- Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? Yes No
- Have you ever been off work due to your spinal symptoms or unable to perform your normal day to day activities? Yes No
 If 'yes', when and for how long?
- What is the nature of the treatment (eg, spinal manipulation, deep tissue massage etc)?

 - Are you still receiving treatment? Yes No
 - If 'no', when did you cease treatment?
- Have you ever consulted a specialist for this condition? Yes No
 If 'yes', provide name and address of specialist and date of last consultation.
- Please provide details of your most recent visit to any other doctor or therapist for this condition. Include date, name and address of doctor or therapist consulted.
- Have you had any ongoing effects of any kind? Eg pain, discomfort or limitations of movement etc? Yes No
 If 'yes', please provide details.
- Is it necessary to avoid lifting or to restrict your daily activities in any way? Yes No
 If 'yes', please provide details.
- Does your regular doctor have details of this condition? Yes No
 If 'no', please provide name and address of doctor who has full details.

Any other condition

- Name of condition (exact diagnosis)
- The cause
- a. Describe symptoms
 b. Date symptoms commenced
 Date symptoms ceased
 c. How often do/did you have symptoms?
- Have you ever been off work or had your normal daily activities restricted in any way because of this condition? Yes No

Date	Duration	Reason/Restriction
/ /		
/ /		
/ /		
- Have you any residual, on-going effects or restriction in your daily activities? Yes No
 If 'yes', please provide details.
- Have you taken regular or occasional medication for this condition? Yes No
 If 'yes', please advise names of medication(s), dosage(s) and frequency.

 Are you still taking this medication? Yes No
- Have you had any other treatment for this condition (eg physiotherapy, operation, alternative remedies)? Yes No
- Have you had any diagnostic investigations (eg scope, scan, x-rays, EEG, ECG etc)? Yes No
- Have you ever been in hospital or received emergency treatment for anything related to this condition? Yes No
- If you answered 'yes' to 7, 8 or 9, please provide details including date, type of treatment and tests.
- Details of your most recent visit to a doctor or other therapist for anything related to this condition.

Date	Reason for consultation, investigations, findings, advice
/ /	
- Has further treatment been recommended for this condition? . Yes No
 If 'yes', please provide details.
- Does your regular doctor have details of this condition? Yes No
 If 'no', please provide name and address of doctor who has full details.

