FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

NEUROLOGICAL DISORDER QUESTIONNAIRE - APPLICANT

TO BE FILLED BY THE APPLICANT

Full name of the Life Insured

Application Number

PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED

1. Please state the precise diagnosis, if known: _____
2. When did the symptoms first occur? _____
3. Do you still have any symptoms? ☐ Yes ☐ No

   If 'Yes', are they constant, variable, improving or progressively worsening? If 'No', when did you last have any of the symptoms? _____

   _____
4. Regarding your symptoms:

   a) Vision - Have you ever experienced:
   - Loss-of or blurring of vision? ☐ Yes ☐ No
   - Double vision or diplopia? ☐ Yes ☐ No
   - Flashing lights? ☐ Yes ☐ No
   - Any other visual disturbance? ☐ Yes ☐ No

   If 'Yes' to any of the above, please provide full details, including severity and date when affected: _____

   _____

   b) Speech and hearing - Have you ever experienced:
   - Slurring or difficulty speaking? ☐ Yes ☐ No
   - Tinnitus (buzzing or ringing) in the ear? ☐ Yes ☐ No
   - Difficulty in hearing? ☐ Yes ☐ No

   If 'Yes' to any of the above, please provide full details, including severity and date when affected: _____

   _____

   c) Weakness, paralysis or abnormal sensation - Have you ever experienced:
   - Numbness or loss of sensation? ☐ Yes ☐ No
   - Pins and needles, tingling or paraesthesia? ☐ Yes ☐ No
   - Limb weakness or loss of muscle power? ☐ Yes ☐ No
   - Difficulty walking, loss of balance, unsteadiness or ataxia? ☐ Yes ☐ No

   If 'Yes' to any of the above, please provide full details, including severity and date when affected: _____

   _____

   d) Bowel and bladder - Have you ever experienced:
   - Altered urinary frequency or incontinence? ☐ Yes ☐ No
   - Altered stool frequency or incontinence? ☐ Yes ☐ No

   If 'Yes' to any of the above, please provide full details, including severity and date when affected: _____

   _____

   e) Others - Have you ever experienced:
   - Vertigo or dizziness? ☐ Yes ☐ No
   - Facial pain or paralysis? ☐ Yes ☐ No
   - Loss of consciousness? ☐ Yes ☐ No
   - Recurrent headaches? ☐ Yes ☐ No
   - Any other neurological or sensory symptoms? ☐ Yes ☐ No

   If 'Yes' to any of the above, please provide full details, including severity and date when affected: _____

   _____

5. Have you been referred to a specialist for further investigation? ☐ Yes ☐ No
   If 'Yes', please provide full details including name, address, speciality of the doctor; visit dates, nature and results of any investigations carried out. If you are awaiting an appointment, please advise when is your next visit due: _____
   _____
6. Please provide details of your current treatment, including names and dosages of each medication. If these drugs or dosages have been changed in the last two years, please provide details including, why: _____
   _____
7. Any history of hospitalisation? When was the hospitalisation and how many times have you been hospitalised in the past? _____
8. Severity:
   a) Is there or has there been, any restriction or limitation on your ability to work? ☐ Yes ☐ No
      If 'Yes', please provide details, including duration of any time taken off-work in the last 2 years: _____
   b) Has the condition caused you to change or reduce your non-occupational activities, (Sports, hobbies, mode of transport, etc?) ☐ Yes ☐ No
      If 'Yes', please provide details: _____
      _____
   c) Do you use a wheelchair or any other form of mobility aid, e.g., a stair lift? ☐ Yes ☐ No
      If 'Yes', please provide details: _____
      _____
   d) Do you require or receive any form of assistance with basic activities around the house such as dressing, preparing food, household work or bathing? ☐ Yes ☐ No
      If 'Yes', please provide details: _____
      _____
   e) Are you eligible for any form of disability benefit or support from the state, from insurance or from an employer? ☐ Yes ☐ No
      If 'Yes', please provide details including type of benefit and amount received: _____
      _____
9. Please provide any additional information on your condition that could be helpful in processing your application: _____
   _____
   _____

Please share copies of all prescriptions, reports, investgations, etc.

I declare, that the answers I have given here, are true to the best of my knowledge, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree, that this form will constitute a part of my application for insurance; and that failure to disclose any material fact known to me, may invalidate the contract.

Place: _____ Date: _____ _____
Signature of the Applicant

VERNACULAR DECLARATION

I have explained the contents of this form and have read out the responses to the Life Insured in his/her local language. He/she has confirmed that the contents are fully understood by him/her.

Name of the Declarant: _____ _____
Address of the Declarant: _____ Signature of the Declarant
_____

_____
Place: _____ Date: _____ Signature of the Life Insured