GENERALI Central
LIFE INSURANCE

Ulcerative Colitis Questionnaire

(Name can be UC/IBD/Crohn's disease) (To be completed by the Physician)

Proposal No: _____ Policy Number: _____ Branch/Channel: _____

Name of the Life Insured: _____

1. When was the patient's Ulcerative Colitis/IBD/Crohn's disease first diagnosed?

   _____

2. How frequently do the symptoms occur? E.g. How often in the last 12 months?

   _____

3. When did the symptoms last occur?

   _____

4. What investigations has the patient undergone? Please provide details including dates of investigations and reports:

   _____

5. Has the patient ever undergone Biopsy? If 'Yes', what were the results?

   _____

6. In your opinion, what is the extent of the disease? (Please tick any of the options given below)

   ☐ Proctitis ☐ Procto sigmoiditis

   ☐ Left-sided colitis ☐ Pancolitis (Universal or total)

7. How would you classify the disease? (Please tick any of the options given below)

   ☐ Mild ☐ Moderate

   ☐ Continuous ☐ Severe

8. Please provide details of the patient's treatment: _____

   Include names of medication (E.g. Sulphasalazine, Azathioprine, Cyclosporin, Steroids, etc.) dosage and frequency:

   Name of medication: _____ Dosage: _____ Frequency: _____

   a. Current: _____

   b. In the past: _____

9. Has the patient undergone any surgical treatment for Ulcerative Colitis?

   If 'Yes', give details including dates: _____

   Is there any evidence of post-operative complications? _____

10. Is there any evidence of extra-colonic complications such as arthropathy, liver disease, ocular disorder, etc?

    _____

11. Has the patient been hospitalised for treatment of Ulcerative Colitis? If 'Yes', please give details including dates & treatment:

    _____

12. Regarding the monitoring of the condition: How often does the patient attend follow-ups & when was the last follow-up?

    _____

13. Has the patient lost significant time (E.g. weeks) off-work due to this condition? ☐ Yes ☐ No

    If 'Yes', please provide details including dates and duration of time off-work: _____

14. In your medical opinion, how would you define the current status of the patient's condition? _____

_____

15. Please provide any additional information on the patient's condition that you feel will be helpful in processing the application:

_____

Name of the Attending Physician: _____

Qualification: _____

Registration Number: _____

Place: _____ Date: _____ _____

Signature of the Physician