GENERALI Central
LIFE INSURANCE

Mental Health Questionnaire - Applicant

(Includes anxiety, stress, depression, somatoform and personality disorders.) (To be filled by Life Insured)

Name of the Life Insured			
Application Number		Branch	

1. What mental health condition(s) do/did you suffer from? Where possible, please mention the medical term as diagnosed by your treating health professional: _____
2. If you have not been given a precise diagnosis/diagnoses, what are/were your symptoms? _____
3. When did you first consult a doctor about your condition/s or symptom/s? _____
4. When did you last consult a doctor about your condition/s or symptom/s? _____
5. How many times have you seen a doctor, for any reason, in the last 12 months? _____
6. Have you fully recovered now? ☐ Yes ☐ No
   i. If 'Yes', please advise, since when: _____
   ii. If 'No', please provide full details of any residual symptoms: _____
7. Has there been more than one episode? ☐ Yes ☐ No
   i. If 'Yes', please comment on the date and duration of each episode: _____
8. Are you aware of any factor or situation, which triggers or exacerbates your symptoms? ☐ Yes ☐ No
   i. If 'Yes', please provide details: _____
9. Please provide details of your treatment. Include names of medication, dosage and frequency. Please share copies of all the reports:

   _____

   Current: _____

   In the Past: _____
10. Have you ever required electroconvulsive therapy (ECT)? ☐ Yes ☐ No
    i. If 'Yes', please provide the date(s) and details, along with copies of the reports: _____
11. Have you ever seen a psychiatrist/specialist or had any treatment as a hospital outpatient? ☐ Yes ☐ No
    i. If 'Yes', please provide full details including date(s) and name of the psychiatrist/hospital: _____
12. Have you ever been an in-patient at a hospital or clinic? ☐ Yes ☐ No
    i. If 'Yes', please provide full details including date(s) and name of the hospital clinic: _____
13. Please provide details of any time taken off-work due to your condition(s). Include the date and duration of each absence:

    _____
14. Have you ever had any suicidal thoughts or attempted suicide? ☐ Yes ☐ No
    i. If 'Yes', please provide full details including the date/s when this occurred and follow-up treatment, if any: _____

    _____
15. Please provide any additional information on your condition that you feel will be helpful in processing your application (i.e. history of alcohol or drug abuse, co-existing physical illness, current weight, and/or behavioural issues):

    _____

Please share copies of doctor's prescriptions, investigation reports, 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 Life Insured

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

_____
Signature of the Life Insured

Place: _____ Date: _____