GASTROINTESTINAL QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

	Full Name:		Date of Birth:	
	Proposal Number:		Dated:	
1	What is the nature of your symptoms?			
	(a) When did you first suffer from these symptoms?			
	(b) When did you last have symptoms?			
	(c) How long do these symptoms occur?			
	(d) How long do these symptoms last?			
2	Specify exact location of the discomfort.			
3	Did the Discomfort spread to other parts of the abdomen, the chest or arms, or the jaw?			
4	Have you ever had shortness of breath with this discomfort? ☐ No ☐ Yes ▸ If "Yes", please give full details.			
5	Have you ever vomited blood, passed black stools or been anaemic? ☐ No ☐ Yes ▸ If "Yes", please give full details.			
6	Have you ever consulted a doctor for this discomfort? ☐ No ☐ Yes ▸ If "Yes". Please give his/her name and address.			
	Name of Doctor:			
	Address:			
7	Have you ever had any of the following investigations of the gastrointestinal tract or gallbladder? ☐ No ☐ Yes ▸ If "Yes", please give the date and result. Barium meal, gastroscopy, barium enema, colonoscopy, cholecystogram, ultrasound of the abdomen.			
8	Have you ever dieted because of these symptoms? ☐ No ☐ Yes			
9	Please provide full details of treatment received and specify whether medical, surgical or both.			

10	Are you still receiving any treatment? ☐ No ☐ Yes ▸ If “Yes”, please give details.			
11	Have you ever had an electrocardiogram done? ☐ No ☐ Yes ▸ If “Yes”, please state by whom and when.			
	Whom:		When:	
12	Please state any further relevant particulars including name and address of personal medical attendant(s).			
	Name of Doctor:			
	Address:			
	Date consulted:			

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	Address:	
	Date consulted:	

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

I agree that this form will constitute part of my proposal for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: