Questionnaire - Chest Pain

Name

Chest Pain

1. When did this occur?



Important information for customers	
Before completing this questionnaire it is important that you read this statement, to sign a declaration stating that you understand and agree to the following:	as you will be required
That if you do not answer the questions honestly and completely, Zurich Life may It is vital that you answer all questions fully as Zurich Life will not necessarily obtai from your doctor in respect of the answers given in this form. Zurich Life may accept or provide terms based on your answers alone.	. , ,
The information requested below is to enable Zurich Life make a decision in some having to request a report from your General Practitioner (GP). If some of the answou please try to obtain this information from your GP.	
If you are in doubt about this declaration please refer to your Financial Adviser or	Zurich Life

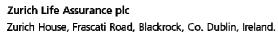
If you have had more than one episode, please answer questions 1 to 7 in respect of each one.

2. What was the pain like? Please tick as many boxes as are appropriate:
How painful was it?
□Mild □Moderately severe □Severe □Other (please describe)
What sort of pain was it?
□Stabbing □Crushing □Constricting or a tightness □Aching □Other (please describe)
Whereabouts did it occur?
□Centrally in the chest □Left side □Right side □High in the chest □Low □Other (please describe)
Did it travel to anywhere else?
□To the shoulder □Down the arm (if so, say which) □To the neck or jaw □Other
(please describe)
What brought it on?
□Exercise or physical work □Awkward posture□Came on for no apparent reason
□Other (please describe)
3. How long did the pain last (for example so many minutes or hours, or perhaps it was on
and off for a period)?

4. What happened next (for example you consulted your doctor, you went to A&E or you were taken to hospital by ambulance)?	
5. Did you have any investigations done? (examples could include blood tests, an x-ray and	
an ECG)	
□Yes □No	
If Yes, what was the test and what were the results?	
6. Were you kept in hospital?	
□Yes □No □Not Applicable	
If Yes, for how long?	
7. What treatment did you have? Please include details of any medicines you were	
prescribed and when you stopped taking them.	

8. Are you	u on any treatment now?	
□Yes	□No	
If Yes, what is this?		
9. Has thi	is cleared up now? Are you symptom-free?	
□Yes	□No	
If No, please	e give details.	
10. Are v	ou still under follow up or review?	
□Yes	□No	
If Yes, whe	en is your next appointment?	

11. Has this condition ever affected your work or your day to day activities?	
□Yes □No	
If Yes, please give full details.	
Declaration	
I declare that the answers to the above questions are true and complete (including any statements written down for me).	
I have read and understood the 'important information for customer' notice on page one of this form and understand that failure to give true and complete answers to the above questions could result in Zurich Life rejecting all or part of any claim that may arise.	
I agree that this declaration shall be incorporated with and form part of the original application form.	
Signature of the life insured Date	



Telephone: 01 283 1301 Fax: 01 283 1578 Website: www.zurichlife.ie Zurich Life Assurance plc is regulated by the Central Bank of Ireland.

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