**Kidney and urinary tract disorders questionnaire**

**Your details**

Name

Application number(s)

**Why we are asking you for this information**

You told us that you have had symptoms relating to your kidney or urinary tract. We’d like some more information on this so that we can assess whether to offer you cover and the terms of that cover.

**What you need to know before completing the questionnaire**

You must take reasonable care to answer the questions fully, honestly, and accurately, to the best of your knowledge.

If you don’t answer the questions correctly your policy may be cancelled, or its terms may be changed, or your claim may be rejected or not fully paid.

**Please answer the following questions**

1. Please tell us what symptoms you have had relating to your kidney or urinary tract:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>From</th>
<th>To</th>
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</tbody>
</table>

2. Have you ever had any of the following tests or investigations in relation to these symptoms?

<table>
<thead>
<tr>
<th>Test or investigation</th>
<th>Date of test</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Awaited</th>
<th>If awaited, please give date result expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystoscopy</td>
<td>M M Y Y</td>
<td></td>
<td></td>
<td></td>
<td>M M Y Y</td>
</tr>
<tr>
<td>Renal ultrasound scan</td>
<td>M M Y Y</td>
<td></td>
<td></td>
<td></td>
<td>M M Y Y</td>
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<tr>
<td>Urine test</td>
<td>M M Y Y</td>
<td></td>
<td></td>
<td></td>
<td>M M Y Y</td>
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<tr>
<td>Renal function test (blood test)</td>
<td>M M Y Y</td>
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<td></td>
<td>M M Y Y</td>
</tr>
<tr>
<td>IVP (injection of dye into vein to show kidneys)</td>
<td>M M Y Y</td>
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<td></td>
<td></td>
<td>M M Y Y</td>
</tr>
<tr>
<td>Other</td>
<td>M M Y Y</td>
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<td>M M Y Y</td>
</tr>
</tbody>
</table>

   If other, please describe below:
3 Has a definite diagnosis been made in relation to your symptoms?  
If 'yes', please confirm if the diagnosis was any of the following:  
- Cystitis  
  - Yes  
  - No  
- Urinary tract infection  
  - Yes  
  - No  
- Bladder infection  
  - Yes  
  - No  
- Kidney infection  
  - Yes  
  - No  
- Kidney stones  
  - Yes  
  - No  
- Nephritis  
  - Yes  
  - No  
- Cancer/tumour  
  - Yes  
  - No  
- Other  
  - Yes  
  - No  
If other, please describe below:

4 Was there an underlying cause given for your symptoms?  
If 'yes', please give details below:

5 Have you required any treatment?  
If 'yes', please give details of your treatment and dates:

<table>
<thead>
<tr>
<th>Name of treatment(s)</th>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
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</table>

6 If you have had kidney stones, have you passed the stone from your last episode?  
- Yes  
- No  
- Not applicable

7 If you currently have a stone or stones in your kidneys, have they ever been described as “staghorn”?  
- Yes  
- No  
- Not applicable

8 Have you ever had raised blood pressure?  
If 'yes', please tell us the date your blood pressure was first found to be raised.  
Since your blood pressure was first found to be raised, has your blood pressure:  
- Stayed the same  
- Reduced  
- Returned to normal  
- Not been re-checked  
- Other  
If other, please describe below:
9 Have you been discharged from any future review or follow up with your GP or other health professional?

☐ Yes  If ‘yes’, please tell us the date you were discharged.

☐ No   If ‘no’, please tell us the date of your next appointment.

10 In the last three years, have you required any time off work because of your symptoms?

☐ Yes  If ‘yes’, please tell us the periods of absence in the space provided:

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<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
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<td>MM YY</td>
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</table>

☐ No   If ‘no’, please tell us the date of your next appointment.

11 If you need more space to answer the questions in this questionnaire, please provide any additional information here:

12 Do you have any reports or letters from the specialist about your condition?

☐ Yes  ☐ No

If ‘yes’, please email us a scanned copy to underwriting.team@uk.zurich.com including the application number(s) in the title of your email, or send them to us at Medical underwriting department, Tricentre One, New Bridge Square, Swindon SN1 1HN.

Declaration

I declare that:

• I have completed the information on this form fully, honestly, and accurately, to the best of my knowledge.

• I am aware that if I haven’t answered the questions correctly my policy may be cancelled, or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a policy means that no cover or other benefits will be provided.

• I have read and understood the declaration in the application, and I consent to my personal data being used in the way described in the Data Protection declaration and the leaflet ‘Your privacy is important to us’.

Signature

Date  DD MM YY