# Eye disorder questionnaire

## Your details

Name

Application number(s)

## Why we are asking you for this information

You told us that you have had an eye disorder. 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. Have you had any of the following symptoms in either eye?

   Please answer all questions by selecting either 'yes' or 'no'. If the answer is 'yes', please tell us the date of your symptoms and which eye was affected by selecting the correct answer below:

| Symptoms | | | From | To | Which eye? | | |
|---|---|---|---|---|---|---|---|
| Blurred vision | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Inflamed eyes | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Inflamed eyelids | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Double vision | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Floaters | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Partial loss of sight | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Total loss of sight | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |
| Other | ☐ Yes | ☐ No | M M Y Y | M M Y Y | ☐ left | ☐ right | ☐ both |

If 'other', please describe below:

2. Has a diagnosis been made? ☐ Yes ☐ No

If 'yes', was the diagnosis any of the following?

| Diagnosis | Please tick | Date of diagnosis |
|---|---|---|
| Cataract | ☐ Yes ☐ No | M M Y Y |
| Glaucoma | ☐ Yes ☐ No | M M Y Y |
| Conjunctivitis | ☐ Yes ☐ No | M M Y Y |
| Corneal ulcer | ☐ Yes ☐ No | M M Y Y |
| Iritis | ☐ Yes ☐ No | M M Y Y |
| Keratitis | ☐ Yes ☐ No | M M Y Y |
| Retinitis | ☐ Yes ☐ No | M M Y Y |
| Optic/Retrobulbar Neuritis | ☐ Yes ☐ No | M M Y Y |
| Keratoconus | ☐ Yes ☐ No | M M Y Y |
| Complete blindness | ☐ Yes ☐ No | M M Y Y |
| Squint | ☐ Yes ☐ No | M M Y Y |
| Lazy eye | ☐ Yes ☐ No | M M Y Y |
| Minor eye infection | ☐ Yes ☐ No | M M Y Y |
| Other | ☐ Yes ☐ No | M M Y Y |

If 'other', please describe below:

_____

3. Have you taken, or are you taking, any medication for your eye disorder? ☐ Yes ☐ No

If 'yes', please tell us the name of the medication prescribed and the period(s) of use:

| Name of medication | From | To |
|---|---|---|
| _____ | M M Y Y | M M Y Y |
| _____ | M M Y Y | M M Y Y |
| _____ | M M Y Y | M M Y Y |

4. Have you had an operation or laser treatment for your eye disorder? ☐ Yes ☐ No

If 'yes', please tell us the type of operation and the date:

| Type of operation | Date |
|---|---|
| _____ | M M Y Y |
| _____ | M M Y Y |
| _____ | M M Y Y |

5. Are you waiting for an operation or laser treatment for your eye disorder? ☐ Yes ☐ No

If 'yes', please tell us the type of operation or treatment and the date it is due:

| Type of operation | Date |
|---|---|
| _____ | M M Y Y |
| _____ | M M Y Y |
| _____ | M M Y Y |

6. Are you waiting for any tests or investigations? ☐ Yes ☐ No

If 'yes', please tell us which tests or investigations you are waiting for and when you expect to have these:

| Type of test or investigation | Date |
|---|---|
| _____ | M M Y Y |
| _____ | M M Y Y |
| _____ | M M Y Y |

7. Do you have any permanent loss of vision in either eye? ☐ Yes ☐ No

If 'yes', please confirm the degree of visual loss by selecting either'yes' or 'no' to all the questions below, and confirm the cause by selecting the correct answer:

| Degree of visual loss | | | Congenital (from birth) | Due to disease | Due to injury |
|---|---|---|---|---|---|
| Partially sighted in right eye | ☐ Yes | ☐ No | ☐ | ☐ | ☐ |
| Partially sighted in left eye | ☐ Yes | ☐ No | ☐ | ☐ | ☐ |
| Total blindness in right eye | ☐ Yes | ☐ No | ☐ | ☐ | ☐ |
| Total blindness in left eye | ☐ Yes | ☐ No | ☐ | ☐ | ☐ |

8. In the last three years has your eyesight:

Please tick ☐ Improved ☐ Stayed the same ☐ Got worse

9. In the last three years, have you required any time off work for your eye disorder? ☐ Yes ☐ No

If 'yes', please give details of the period(s) of absence:

| From | To |
|---|---|
| M M Y Y | M M Y Y |
| M M Y Y | M M Y Y |
| M M Y Y | M M Y Y |
| M M Y Y | M M Y Y |

10. Please provide any additional information on your condition which may help us to process your application:

_____

11. 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, Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

## 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 the Zurich data protection leaflet 'Your privacy is important to us' and I agree to the personal information I have provided in this form being used in the ways described.

Signature

Date D D M M Y Y Y Y



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