Gynaecological questionnaire

Your details

Name

Application number(s)

Why we are asking you for this information

You told us that you have had gynaecological symptoms. 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. When did you last have a smear test? Please give the month and year: M M Y Y

2. Was your last smear test normal? ☐ Yes ☐ No

   If 'no', please confirm the precise result or diagnosis below:

   Result or diagnosis

   Borderline changes ☐ Yes ☐ No

   HPV wart virus infection ☐ Yes ☐ No

   Mild dyskaryosis/CIN1 ☐ Yes ☐ No

   Moderate dyskaryosis/CIN2 ☐ Yes ☐ No

   Severe dyskaryosis/CIN3 ☐ Yes ☐ No

   Other ☐ Yes ☐ No

   If 'other', please describe below: ☐ Yes ☐ No

3. Have you ever had any of the following treatments? If 'yes', please give the date of the treatment.

Treatment	Please tick		Date
Laser treatment	☐ Yes	☐ No	M M Y Y
Coning/cone biopsy	☐ Yes	☐ No	M M Y Y
Cold coagulation	☐ Yes	☐ No	M M Y Y
Dilation and curettage (D&C)	☐ Yes	☐ No	M M Y Y
Colposcopy	☐ Yes	☐ No	M M Y Y
Laparoscopy	☐ Yes	☐ No	M M Y Y
Hysteroscopy	☐ Yes	☐ No	M M Y Y
Diathermy	☐ Yes	☐ No	M M Y Y
Other	☐ Yes	☐ No	M M Y Y

If 'other', please describe below:

_____

4. When is your next smear test due? Please give the month and year: M M Y Y

5. Have you had a hysterectomy? ☐ Yes ☐ No

If 'yes', please confirm the reason for the hysterectomy and the date of the operation below:

Reason for hysterectomy	Date
_____	M M Y Y

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

If 'yes', please tell us the treatment or investigations planned and the proposed date for these:

Treatment or investigation	Date
_____	M M Y Y
_____	M M Y Y
_____	M M Y Y
_____	M M Y Y

7. Have you ever been diagnosed with any of the following disorders?

If 'yes', please give the date of the diagnosis.

Disorder			Date diagnosed
Endometriosis	☐ Yes	☐ No	M M Y Y
Adhesions	☐ Yes	☐ No	M M Y Y
Polycystic ovarian syndrome	☐ Yes	☐ No	M M Y Y
Fibroids	☐ Yes	☐ No	M M Y Y
Ovarian cysts	☐ Yes	☐ No	M M Y Y
Cancer/tumour	☐ Yes	☐ No	M M Y Y
Other	☐ Yes	☐ No	M M Y Y

If 'other', please describe below:

_____

8. In the last three years, have you needed any time off work for your gynaecological disorder? ☐ Yes ☐ No

If 'yes', please tell us the periods of absence below:

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

9. Please provide any additional information on your condition which may help us to assess your application below:

10. 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

PDF1555001 (720793) (07/22) (LPP)

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