



**Gastrointestinal disorder (...continued)**

7. Have any tests or investigations been completed?  Yes  No

X-Ray-type: Dates and results: \_\_\_\_\_

Gastroscopy: Dates and results: \_\_\_\_\_

Colonoscopy: Dates and results: \_\_\_\_\_

Other, specify: \_\_\_\_\_

8. Are you currently taking medication?  Yes  No

If so, details: \_\_\_\_\_

9. Have you been advised to undergo surgery?  Yes  No

If so, details: \_\_\_\_\_

10. Are you free of all symptoms?  Yes  No

If yes, since when? \_\_\_\_\_

11. Name and address of attending physician: \_\_\_\_\_

I, the undersigned, declare that the above answers are true and complete and shall form part of my application for insurance with Humania Assurance.

Signed at: \_\_\_\_\_

Date: 

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year / month / day

Signature of witness: \_\_\_\_\_

Signature of person to be insured: \_\_\_\_\_