



QUESTIONNAIRE: HYPOTHYROIDISM
(UNDERACTIVE THYROID)

Name:

Date of birth:

Application reference:.....

1. Was the condition diagnosed in the last 12 months? YES / NO
2. Are you under the care of a consultant? YES / NO
3. Do you see the GP/Nurse to have your thyroxin levels checked more than **twice** a year? YES / NO

Declaration:

I understand that the information given on this questionnaire must be full and accurate. That failure to take reasonable care in answering any questions may result in a claim not being paid, the underwriting terms being changed, the cover being cancelled and / or treatment costs already paid by us being reclaimed.

Name* (please print):

Signature: **Date:**

***Of the person named above, or the Planholder (Personal Healthcare) / principal member (Business / Corporate Healthcare) if that person is a child under the age of 16.**